

2186

CERTIFICATE OF DEATH

02157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheneyville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D.O.A. Prince Georges Gen Hosp</u>		d. STREET ADDRESS <u>2201 Gaylord Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGINIA ELLA ADAIR</u>		4. DATE OF DEATH Month Day Year <u>February 3, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chrysalis Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William J. Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Doris A. Watson</u>		Address <u>2201 Gaylord Dr. Bradbury Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause primary for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>170X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 1957</u> to <u>February 3, 1959</u> , that I last saw the deceased alive on <u>February 2, 1959</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Forest K. Harris II</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>800 New Hampshire Ave. N.W. Wash, D.C. Feb 3, 1959</u>	
PHYSICIAN'S NAME (Type) <u>FOREST K. HARRIS II</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 6, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		ADDRESS <u>800 Washington, N.E.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Caribug L. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A. H. Day, coroner notified by phone

CERTIFICATE OF DEATH

2186

DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH: 1918

PLACE OF DEATH: Home

AGE: 6

SEX: Male

RACE: White

EDUCATION: None

OCCUPATION: None

RELIGION: None

CAUSE OF DEATH: Scarlet fever

PERIOD OF ILLNESS: 10 days

PREVIOUS ILLNESS: None

DIAGNOSIS: Scarlet fever

DATE OF REPORT: 1918

REPORTED BY: Dr. J. H. Smith

SIGNATURE: J. H. Smith

DATE: 1918

DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH: 1918

PLACE OF DEATH: Home

AGE: 6

SEX: Male

RACE: White

EDUCATION: None

OCCUPATION: None

RELIGION: None

CAUSE OF DEATH: Scarlet fever

PERIOD OF ILLNESS: 10 days

PREVIOUS ILLNESS: None

DIAGNOSIS: Scarlet fever

DATE OF REPORT: 1918

REPORTED BY: Dr. J. H. Smith

SIGNATURE: J. H. Smith

DATE: 1918

CERTIFICATE OF DEATH

Reg. Dist. No.

02158

2187

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6314 Tuckerman Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle May Last Adams				4. DATE OF DEATH Month February Day 28 , Year 19 59-			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 2, 1871	9. AGE (In years last birthday) 87 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Stewart Mc Coy				14. MOTHER'S MAIDEN NAME Mahala Caburn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Beulah Bartholomew Riverdale Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis (multiple) DUE TO Cerebral Thrombosis (multiple) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis (multiple) DUE TO Cerebral Thrombosis (multiple) (c) Cerebral Thrombosis (multiple)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Asthma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Set , 19 53 , to May , 19 59 , that I last saw the deceased alive on 26 Feb , 19 59 , and that death occurred at 3 30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W.C. ETIENNE M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 4712 Parkway Rd			
PHYSICIAN'S NAME (Type) W.C. ETIENNE				College Park, Md 2/4/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF March 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE MAR 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

CERTIFICATE OF DEATH

MASS. REG. NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF NURSE

NAME OF PHYSICIAN

NAME OF SURGEON

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PODIATRIST

NAME OF VETERINARIAN

NAME OF PHARMACEUTICIAN

NAME OF LABORATORY

NAME OF RADIOLOGIST

NAME OF PATHOLOGIST

NAME OF HISTOLOGIST

NAME OF CYTOLOGIST

NAME OF MICROSCOPIC

NAME OF RADIOLOGICAL

NAME OF RADIOLOGICAL

2244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Pr Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hall Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural - Hall, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Upper Marlboro Md R.F.D #2 Box 103</u>				d. STREET ADDRESS <u>Upper Marlboro Md R.F.D #2 Box 103</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Garland</u> Middle <u>Sigler</u> Last <u>Arnold</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29 1886</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>		IF UNDER 24 HRS. Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY (Own) <u>General Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Calvin Ezra Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Alta Sigler Sigler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>317-36-9389</u>			
17. INFORMANT Address <u>Box 103</u>				17. INFORMANT <u>Mrs. Nellie Arnold, Upper Marlboro Md R.F.D #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 Years</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 Weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>49</u> , to <u>Feb 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 31</u> , 19 <u>59</u> , and that death occurred at <u>5:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Suit Ritchie</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>7005 Ritchie Rd SE 2/4/59</u>			
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie M.D.</u>				Washington 27 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Oak Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Mitchellville, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home - Marlboro, Md.</u>				ADDRESS <u>Upper</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILL BROAD

CONFIDENTIAL

WILL BROAD

11111111

CERTIFICATE OF DEATH

Reg. Dist. No.

2245

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE	c. LENGTH OF STAY IN 1b 10 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSP.		d. STREET ADDRESS 427 DELAWARE S.W.		
3. NAME OF DECEASED (Type or print) HARRY E. BAILEY		4. DATE OF DEATH 2/21/59		
S. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/79	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 79 Days 79 Hours 79 Min. 79		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME WALTER BAILEY		14. MOTHER'S MAIDEN NAME MILLIE FAIRFAX		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		
17. INFORMANT DECEASED		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 002x DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 15 years			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/21/58 , to 2/21/59 , that I last saw the deceased alive on 2/20/59 , and that death occurred at 7:34 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) GLENN DALE HOSP. DATE SIGNED 2/21/59 ACTUAL SIGNATURE MOE WEISS MD. PHYSICIAN'S NAME (Type) GLENN DALE, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-59		
22c. NAME OF CEMETERY OR CREMATORY Boyd's Methodist Ch.		22d. LOCATION (City, town, or county) (State) Boyd's Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Galtner		24a. REC'D BY REGISTRAR DATE FEB 25 '59		
24b. REGISTRAR'S SIGNATURE Arthur L. Hanks				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY, N. Y.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

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DATE OF ARRIVAL

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DATE OF ARRIVAL

PLACE OF ARRIVAL

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
Reg. Dist. No. 02161									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville d. STREET ADDRESS 1 4219 Kennedy St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Emily Middle Jane Last Barnes					4. DATE OF DEATH Month Feb Day 24 Year 19 59				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Nov 1870		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Walker					14. MOTHER'S MAIDEN NAME Mary McKay				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ruebie B. Heironimus, 6625 Willston Place, Falls Church, Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 13 days 19	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from Jan 1st, 1959, to Feb 24th, 1959, that I last saw the deceased alive on Feb 24th, 1959, and that death occurred at 11:01 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Till Bergemann M.D. 4314 Gallatin St, Hyattsville Md. 2/24/59 PHYSICIAN'S NAME (Type) Dr. Till Bergemann, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 28th, 1959		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery			22d. LOCATION (City, town, or county) (State) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.W. Chambers Company, Riverdale, Md.					24a. RECEIVED BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02162

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. STREET ADDRESS Rt. 2, Box 156 A Pine Street	
3. NAME OF DECEASED (Type or print) Anthony Barowsky		4. DATE OF DEATH Month February Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-1917
9. AGE (in years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 41 Days 26 Hours 19 Min. 59	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng. Research Corp.		12. KIND OF BUSINESS OR INDUSTRY Oklahoma	
13. FATHER'S NAME Stephen Barowsky		14. MOTHER'S MAIDEN NAME Stella Schalsky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WW 2		16. SOCIAL SECURITY NO. Hit by automobile	
17. INFORMANT Hospital Records; Leland Memorial Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Laceration of inferior vena cava, laceration of liver and right kidney. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Hit by automobile		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 7.20 a.m. 2-21-59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Laurel Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 27, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY St Marys Cem.		22d. LOCATION (City, town, or county) (State) Laurel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kline		24a. REC'D BY REGISTRAR DATE MAR 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
CASH OFF

MARY AND STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Deceased in order certified

Residence

1911-12-11

Deceased in order certified

Residence

1911-12-11

Deceased in order certified

1911-12-11

1911-12-11

1911-12-11

1911-12-11

1911-12-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2130

CERTIFICATE OF DEATH

Reg. Dist. No.

02163

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4/ Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hospital</u>		d. STREET ADDRESS <u>604 4th St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Batts</u>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 22, 1959</u>
9. AGE (In years last birthday) yrs. <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Allen Batts</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Lee Skutt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert Allen Batts</u>		Address <u>604 4th St Laurel</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO <u>Pneumothorax</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2:53 AM</u> , 19 <u>59</u> , to <u>6:00 AM</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>59</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Wingfield</u>		M.D. <u>Laurel, Maryland</u> DATE SIGNED <u>Feb 22 1959</u>	
PHYSICIAN'S NAME (Type) <u>Dr. R.C. Wingfield</u>		<u>311 Thomas Drive Laurel, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>23/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. ...</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>...</u>			

207627/XV3

CERTIFICATE OF DEATH

1910

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1865</u></p>	
<p>5. Place of birth: <u>Massachusetts</u></p>		<p>6. Date of death: <u>Dec 10, 1910</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Signature of registrar: <u>W. H. Jones</u></p>	
<p>11. Signature of informant: <u>John J. Brown</u></p>		<p>12. Signature of witness: <u>John J. Brown</u></p>	
<p>13. Signature of undertaker: <u>John J. Brown</u></p>		<p>14. Signature of funeral home: <u>John J. Brown</u></p>	
<p>15. Signature of cemetery: <u>John J. Brown</u></p>		<p>16. Signature of burial place: <u>John J. Brown</u></p>	
<p>17. Signature of interment: <u>John J. Brown</u></p>		<p>18. Signature of final disposition: <u>John J. Brown</u></p>	
<p>19. Signature of final disposition: <u>John J. Brown</u></p>		<p>20. Signature of final disposition: <u>John J. Brown</u></p>	
<p>21. Signature of final disposition: <u>John J. Brown</u></p>		<p>22. Signature of final disposition: <u>John J. Brown</u></p>	
<p>23. Signature of final disposition: <u>John J. Brown</u></p>		<p>24. Signature of final disposition: <u>John J. Brown</u></p>	
<p>25. Signature of final disposition: <u>John J. Brown</u></p>		<p>26. Signature of final disposition: <u>John J. Brown</u></p>	
<p>27. Signature of final disposition: <u>John J. Brown</u></p>		<p>28. Signature of final disposition: <u>John J. Brown</u></p>	
<p>29. Signature of final disposition: <u>John J. Brown</u></p>		<p>30. Signature of final disposition: <u>John J. Brown</u></p>	
<p>31. Signature of final disposition: <u>John J. Brown</u></p>		<p>32. Signature of final disposition: <u>John J. Brown</u></p>	
<p>33. Signature of final disposition: <u>John J. Brown</u></p>		<p>34. Signature of final disposition: <u>John J. Brown</u></p>	
<p>35. Signature of final disposition: <u>John J. Brown</u></p>		<p>36. Signature of final disposition: <u>John J. Brown</u></p>	
<p>37. Signature of final disposition: <u>John J. Brown</u></p>		<p>38. Signature of final disposition: <u>John J. Brown</u></p>	
<p>39. Signature of final disposition: <u>John J. Brown</u></p>		<p>40. Signature of final disposition: <u>John J. Brown</u></p>	
<p>41. Signature of final disposition: <u>John J. Brown</u></p>		<p>42. Signature of final disposition: <u>John J. Brown</u></p>	
<p>43. Signature of final disposition: <u>John J. Brown</u></p>		<p>44. Signature of final disposition: <u>John J. Brown</u></p>	
<p>45. Signature of final disposition: <u>John J. Brown</u></p>		<p>46. Signature of final disposition: <u>John J. Brown</u></p>	
<p>47. Signature of final disposition: <u>John J. Brown</u></p>		<p>48. Signature of final disposition: <u>John J. Brown</u></p>	
<p>49. Signature of final disposition: <u>John J. Brown</u></p>		<p>50. Signature of final disposition: <u>John J. Brown</u></p>	
<p>51. Signature of final disposition: <u>John J. Brown</u></p>		<p>52. Signature of final disposition: <u>John J. Brown</u></p>	
<p>53. Signature of final disposition: <u>John J. Brown</u></p>		<p>54. Signature of final disposition: <u>John J. Brown</u></p>	
<p>55. Signature of final disposition: <u>John J. Brown</u></p>		<p>56. Signature of final disposition: <u>John J. Brown</u></p>	
<p>57. Signature of final disposition: <u>John J. Brown</u></p>		<p>58. Signature of final disposition: <u>John J. Brown</u></p>	
<p>59. Signature of final disposition: <u>John J. Brown</u></p>		<p>60. Signature of final disposition: <u>John J. Brown</u></p>	
<p>61. Signature of final disposition: <u>John J. Brown</u></p>		<p>62. Signature of final disposition: <u>John J. Brown</u></p>	
<p>63. Signature of final disposition: <u>John J. Brown</u></p>		<p>64. Signature of final disposition: <u>John J. Brown</u></p>	
<p>65. Signature of final disposition: <u>John J. Brown</u></p>		<p>66. Signature of final disposition: <u>John J. Brown</u></p>	
<p>67. Signature of final disposition: <u>John J. Brown</u></p>		<p>68. Signature of final disposition: <u>John J. Brown</u></p>	
<p>69. Signature of final disposition: <u>John J. Brown</u></p>		<p>70. Signature of final disposition: <u>John J. Brown</u></p>	
<p>71. Signature of final disposition: <u>John J. Brown</u></p>		<p>72. Signature of final disposition: <u>John J. Brown</u></p>	
<p>73. Signature of final disposition: <u>John J. Brown</u></p>		<p>74. Signature of final disposition: <u>John J. Brown</u></p>	
<p>75. Signature of final disposition: <u>John J. Brown</u></p>		<p>76. Signature of final disposition: <u>John J. Brown</u></p>	
<p>77. Signature of final disposition: <u>John J. Brown</u></p>		<p>78. Signature of final disposition: <u>John J. Brown</u></p>	
<p>79. Signature of final disposition: <u>John J. Brown</u></p>		<p>80. Signature of final disposition: <u>John J. Brown</u></p>	
<p>81. Signature of final disposition: <u>John J. Brown</u></p>		<p>82. Signature of final disposition: <u>John J. Brown</u></p>	
<p>83. Signature of final disposition: <u>John J. Brown</u></p>		<p>84. Signature of final disposition: <u>John J. Brown</u></p>	
<p>85. Signature of final disposition: <u>John J. Brown</u></p>		<p>86. Signature of final disposition: <u>John J. Brown</u></p>	
<p>87. Signature of final disposition: <u>John J. Brown</u></p>		<p>88. Signature of final disposition: <u>John J. Brown</u></p>	
<p>89. Signature of final disposition: <u>John J. Brown</u></p>		<p>90. Signature of final disposition: <u>John J. Brown</u></p>	
<p>91. Signature of final disposition: <u>John J. Brown</u></p>		<p>92. Signature of final disposition: <u>John J. Brown</u></p>	
<p>93. Signature of final disposition: <u>John J. Brown</u></p>		<p>94. Signature of final disposition: <u>John J. Brown</u></p>	
<p>95. Signature of final disposition: <u>John J. Brown</u></p>		<p>96. Signature of final disposition: <u>John J. Brown</u></p>	
<p>97. Signature of final disposition: <u>John J. Brown</u></p>		<p>98. Signature of final disposition: <u>John J. Brown</u></p>	
<p>99. Signature of final disposition: <u>John J. Brown</u></p>		<p>100. Signature of final disposition: <u>John J. Brown</u></p>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

2246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN lb 14 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5710 Allentown Road	
d. STREET ADDRESS 5710 Allentown Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Barnes Compton BEALL		4. DATE OF DEATH Month Day Year 2 3 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-1890
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Samuel Beall		14. MOTHER'S M maiden NAME Virginia B. Crandall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Richard E. Beall		Address Camp Springs	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Metastasis to Liver DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-3-1958 to 2-3-1959, that I lost saw the deceased olive on 1-24-1959, and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter D. Hays		ADDRESS (Street, city or town, state) 6124 Central Ave. Capital Heights Md.	
DATE SIGNED 2-3-59			
PHYSICIAN'S NAME (Type) Peter D. Hays			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Stuntland Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. Wash. D.C.		24a. REC'D BY REGISTRAR DATE FEB 6 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hays			

VS A15 (4)
ISM 10/57

VS A15 (4)
ISM 10/57

11

A blank, aged, cream-colored page with two dark, irregular holes punched through it, one near the top and one near the bottom. The paper has a slightly textured appearance and some minor discoloration consistent with age.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2191

CERTIFICATE OF DEATH

Reg. Dist. No.

02165

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 25 Minutes			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 5304 Hamilton St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lester G Berry				4. DATE OF DEATH Month Day Year Feb. 15 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-87		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Govt			10b. KIND OF BUSINESS OR INDUSTRY Printer		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Elliott Berry				14. MOTHER'S MAIDEN NAME Edna ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes 1915 to 1916			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Ida V Berry Hyattsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis of heart DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 19 58 , to 2-15 , 19 59 , that I last saw the deceased alive on 2-15 , 19 59 , and that death occurred at 8:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George Magenge M.D. 3717-38th Ave. S.W. 2-16-59 Cottage City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2/18/59		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE FEB 19 59	24b. REGISTRAR'S SIGNATURE Arthur E. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No.

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Signature of witness

13. Signature of jury

14. Signature of coroner

15. Signature of undertaker

16. Signature of funeral home

17. Signature of cemetery

18. Signature of church

19. Signature of family

20. Signature of neighbors

21. Signature of friends

22. Signature of community

23. Signature of state

24. Signature of nation

25. Signature of world

26. Signature of universe

27. Signature of everything

28. Signature of nothing

29. Signature of somewhere

30. Signature of nowhere

31. Signature of when

32. Signature of never

33. Signature of always

34. Signature of forever

35. Signature of never-ending

2192

CERTIFICATE OF DEATH

02160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 4636 Hillside Rd., S.E., #3			
3. NAME OF DECEASED (Type or print) First Middle Last Rosa Lee Berry				4. DATE OF DEATH Month 2 Day 18 Year 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/24/15	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Days work		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Arthur Adams				14. MOTHER'S MAIDEN NAME Anna Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 20 Mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) COR PULMONALE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/7, 1958, to 2/18, 1959, that I last saw the deceased alive on 2/18, 1959, and that death occurred at 8:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Moe Weiss				ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 2/18/59			
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-59		22c. NAME OF CEMETERY OR CREMATORY (2-24-59) Arlington Natl.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Palmer-Funk Home 1113 H St NE				24a. REC'D BY REGISTRAR DATE FEB 20 '59		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE CHAIRMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG239 2-20-59 at

2193

CERTIFICATE OF DEATH

Reg. Dist. No.

02167

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>		c. LENGTH OF STAY IN 1b <u>5 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adolph</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>3401 Chatham Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cordelia Blackburn</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>59</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>James</u>		14. MOTHER'S MAIDEN NAME <u>Susan Shelton</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Martha Track</u>		Address <u>3401 Chatham Rd. Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenaline failure</u> <u>172 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic Adrenaline carcinoma</u> DUE TO (c) <u>Adrenaline carcinoma of the corpus uteri</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Feb. 7</u> , 19 <u>59</u> , to <u>Feb. 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 13</u> , 19 <u>59</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>John S. Hought</u>		M.D. _____					
PHYSICIAN'S NAME (Type) <u>Dr. John S. Hought</u>		<u>3306 Rhode Island Ave. Mt. Rainier Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Feb. 17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Adams Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hought</u>		ADDRESS <u>254 Small St</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hought</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

A PLACE FOR THE

DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNICITY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02168

2194

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. d. STREET ADDRESS 1360 Peabody St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Bourbon		4. DATE OF DEATH Month Feb Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 22, 1959
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 18 Hours 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A./		12. CITIZEN OF WHAT COUNTRY? U.S.A./	
13. FATHER'S NAME John Bourbon		14. MOTHER'S MAIDEN NAME Mary Winifred McBride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Parents		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asp 16 gastric contents & atelectasis 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestinal obstruction DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-22-1959 , to 2-24-1959 , that I last saw the deceased alive on 2-24-1959 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A Deitz		DATE SIGNED Hyattsville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/59	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR 2-2-59		24b. REGISTRAR'S SIGNATURE 2-2-59	

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Date of death (Month, Day, Year)

6. Time of death (Hour, Minute)

7. Cause of death (Immediate cause)

8. Cause of death (Underlying cause)

9. Cause of death (Contributing cause)

10. Place of death (City, State, Country)

11. Signature of physician (Print name)

12. Signature of physician (Print name)

13. Signature of physician (Print name)

14. Signature of physician (Print name)

15. Signature of physician (Print name)

16. Signature of physician (Print name)

17. Signature of physician (Print name)

18. Signature of physician (Print name)

19. Signature of physician (Print name)

20. Signature of physician (Print name)

21. Signature of physician (Print name)

22. Signature of physician (Print name)

23. Signature of physician (Print name)

24. Signature of physician (Print name)

25. Signature of physician (Print name)

26. Signature of physician (Print name)

27. Signature of physician (Print name)

28. Signature of physician (Print name)

29. Signature of physician (Print name)

30. Signature of physician (Print name)

31. Signature of physician (Print name)

32. Signature of physician (Print name)

33. Signature of physician (Print name)

34. Signature of physician (Print name)

35. Signature of physician (Print name)

36. Signature of physician (Print name)

37. Signature of physician (Print name)

38. Signature of physician (Print name)

39. Signature of physician (Print name)

40. Signature of physician (Print name)

41. Signature of physician (Print name)

42. Signature of physician (Print name)

43. Signature of physician (Print name)

44. Signature of physician (Print name)

45. Signature of physician (Print name)

RECEIVED
MAY 10 1964
BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02164

FOR STATE
HEALTH DEPT.

2247

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4611-Branch Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ellen Catherine Boyd</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 14, 1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Bolger</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William C. Boyd</u> Address <u>233 Mississippi Ave SE Washington D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Feb 14, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-17-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEE FUNERAL HOME</u> ADDRESS <u>300 4th ST. N.E.</u>				24a. REC'D BY REGISTRAR <u>FEB 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

2195

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fred Beale		4. DATE OF DEATH Month February Day 25 Year 19 59	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/30/90	
9. AGE (In years last birthday) 69/68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James Payne Brann		14. MOTHER'S MAIDEN NAME Lena Dunaway Brann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dorothy Dudd Daughter Address Address Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senescent Atherosclerosis DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/23 , 19 59 , to 2/25 , 19 59 ; that I last saw the deceased alive on February 25 , 19 59 , and that death occurred at 3:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3408 Rhode Island Ave Mt. Ranier, Md. DATE SIGNED ACTUAL SIGNATURE Leon R. Levitsky M.D. M.D. 3408 Rhode Island Ave Mt. Ranier, Md. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M.D. 3408 Rhode Island Ave Mt. Ranier, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-59	
22c. NAME OF CEMETERY OR CREMATORY Baptist Ch. Cemetery		22d. LOCATION (City, town, or county) (State) Farnham, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. ADDRESS 317 Pa. Ave., SE DC3		24a. REC'D BY REGISTRAR DATE FEB 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

FILE NO. 100

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

NAME OF DECEASED
MRS. J. M. BROWN

AGE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Justice

Signature of Sheriff

Signature of Constable

Signature of Town Clerk

Signature of School Committee

Signature of Board of Health

Signature of Board of Sanitation

Signature of Board of Public Health

Signature of Board of Civil Service

Signature of Board of Education

Signature of Board of Trade

Signature of Board of Agriculture

Signature of Board of Fisheries

Signature of Board of Forestry

Signature of Board of Conservation

Signature of Board of Natural Resources

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2248

CERTIFICATE OF DEATH

Reg. Dist. No.

02171

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine Rural</u>				c. LENGTH OF STAY IN 1b <u>Brandywine Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Brandywine Rural</u>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>ELLA</u> Last <u>Brauner</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20 1846</u>	9. AGE (In years last birthday) <u>112</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>R. Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Jane Hawkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT <u>Peter Moore Brandywine Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho-Pneumonia</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Endocarditis & Myocardial Failure</u> DUE TO (c) <u>Senescence</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9 a.m.</u> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 9</u> , 19 <u>59</u> , to <u>Feb 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>59</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vaher M. Seron</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Waldorf, Md 2/23/59</u>			
PHYSICIAN'S NAME (Type) <u>VAHER M. SERON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 25 1959</u>		<u>Asbury M.E.</u>		<u>Brandywine, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>				ADDRESS <u>Waldorf Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2196

CERTIFICATE OF DEATH

Reg. Dist. No.

02172

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 8134 Penbrook Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elijah		First Breeden		Middle Breeden		Last Breeden	
4. DATE OF DEATH Feb. 16 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 12, 1924		9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Frozen Food Lockers		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Breeden				14. MOTHER'S MAIDEN NAME Clara ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		(If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Kathryn Breeden Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Stomach DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 52 to 2-16 , 19 57 , that I last saw the deceased alive on 2-15 , 19 57 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4314 Gallatin St. Hyattsville Md.							
ACTUAL SIGNATURE Dr. Aaron Dietz		M.D. 4314 Gallatin St. Hyattsville Md.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 19 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2172

CERTIFICATE OF DEATH

Reg. Dist. No.

02173

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home				e. STREET ADDRESS 5805 Queens Chapel Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ella Middle C. Last Brennan				4. DATE OF DEATH Month Feb Day 21 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 8, 1873		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Brennan				14. MOTHER'S MAIDEN NAME Catherine Tounney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records at Sacred Heart Home Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 14 days 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/21 , 19 53 , to 2/21 , 19 59 , that I last saw the deceased alive on Feb 19 , 19 59 , and that death occurred at 3:10 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas F Collins M.D. 322 H St. N.E. 2/21/59 PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D. Washington D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington, D.C.				24a. REC'D. BY REGISTRAR DATE FEB 24 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CERTIFICATE OF DEATH

DECEASED NAME JAMES J. COLLINS		SEX Male		AGE 45	
DATE OF BIRTH 10/21/1875		PLACE OF BIRTH Boston, Mass.		DATE OF DEATH 11/15/1920	
TIME OF DEATH 10:30 A.M.		PLACE OF DEATH Home		CAUSE OF DEATH Arteriosclerotic heart disease	
DISEASE OR INJURY Arteriosclerotic heart disease		PERMANENT DAMAGE None		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED James J. Collins		SIGNATURE OF WITNESS J. J. Collins		SIGNATURE OF PHYSICIAN J. J. Collins	
SIGNATURE OF REGISTRAR J. J. Collins		SIGNATURE OF CLERK J. J. Collins		SIGNATURE OF NOTARY J. J. Collins	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-238 2/13/59.cac.

2170

CERTIFICATE OF DEATH

02174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>same</i> b. COUNTY <i>same</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>14 same</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#7 Audubon Court</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GERALD CASSEL BRISTOW</i>		4. DATE OF DEATH <i>FEB 8 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1905 Jan 12 1903</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Weather Bureau</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U S Government</i>	
11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>William R Bristow</i>		14. MOTHER'S MAIDEN NAME <i>Pearl C ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Charlotte V. Bristow</i>		Address <i>College Park, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerotic Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Jan 19 5 19 59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 5 1959</i> to <i>Feb 8 1959</i> , that I last saw the deceased alive on <i>FEB 8 1959</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.		DATE SIGNED <i>4713 - BERWYN Rd</i>	
ACTUAL SIGNATURE <i>W. C. Etienne</i> M.D.		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <i>W. C. ETIENNE</i>		College Park, Md. <i>2/8/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>Feb 10, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>FEB 10 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

2150

1910

1. Name of deceased: JOHN J. HENRY

2. Sex: Male

3. Age: 45

4. Date of death: April 1, 1910

5. Time of death: 10:30 A.M.

6. Place of death: Home

7. Cause of death: Heart Disease

8. Duration of illness: 2 weeks

9. Name of physician: Dr. J. H. Smith

10. Name of undertaker: John J. Smith

11. Name of funeral home: John J. Smith

12. Name of cemetery: John J. Smith

13. Name of church: John J. Smith

14. Name of minister: John J. Smith

15. Name of sexton: John J. Smith

16. Name of registrar: John J. Smith

17. Name of coroner: John J. Smith

18. Name of jury: John J. Smith

19. Name of witness: John J. Smith

20. Name of jury: John J. Smith

21. Name of witness: John J. Smith

22. Name of jury: John J. Smith

23. Name of witness: John J. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2249

CERTIFICATE OF DEATH

Reg. Dist. No.

02175

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AF Base				c. LENGTH OF STAY IN 1b 16 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (27)			
f. STREET ADDRESS 501 73 Place				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Payne Last Butler				4. DATE OF DEATH Month February Day 5 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 September 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John P Butler				14. MOTHER'S MAIDEN NAME Mattie Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 420-14-9760		17. INFORMANT Myrtle G Wetzel 501 73 Place Washington, D C			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident and Bronchopneumonia 331x DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 16 Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 Jan 1959, to 5 Feb 1959, that I last saw the deceased alive on 5 Feb 1959, and that death occurred at 4:25 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Reginald P McManus M.D. USAF Hospital Andrews 5 Feb 59 PHYSICIAN'S NAME (Type) REGINALD P MCMANUS CAPT USAF (MC) Andrews Air Force Base							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/ 59		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lees Sons 4th & Mass. Ave. N.E. Washington D.C.				24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death	
6. Place of birth		7. Usual residence		8. Cause of death		9. Duration of illness		10. Place of death	
11. Name of physician		12. Name of funeral director		13. Name of informant		14. Signature of informant		15. Signature of registrar	
16. Name of hospital		17. Name of cemetery		18. Name of burial place		19. Name of burial place		20. Name of burial place	
21. Name of burial place		22. Name of burial place		23. Name of burial place		24. Name of burial place		25. Name of burial place	
26. Name of burial place		27. Name of burial place		28. Name of burial place		29. Name of burial place		30. Name of burial place	
31. Name of burial place		32. Name of burial place		33. Name of burial place		34. Name of burial place		35. Name of burial place	
36. Name of burial place		37. Name of burial place		38. Name of burial place		39. Name of burial place		40. Name of burial place	
41. Name of burial place		42. Name of burial place		43. Name of burial place		44. Name of burial place		45. Name of burial place	
46. Name of burial place		47. Name of burial place		48. Name of burial place		49. Name of burial place		50. Name of burial place	
51. Name of burial place		52. Name of burial place		53. Name of burial place		54. Name of burial place		55. Name of burial place	
56. Name of burial place		57. Name of burial place		58. Name of burial place		59. Name of burial place		60. Name of burial place	
61. Name of burial place		62. Name of burial place		63. Name of burial place		64. Name of burial place		65. Name of burial place	
66. Name of burial place		67. Name of burial place		68. Name of burial place		69. Name of burial place		70. Name of burial place	
71. Name of burial place		72. Name of burial place		73. Name of burial place		74. Name of burial place		75. Name of burial place	
76. Name of burial place		77. Name of burial place		78. Name of burial place		79. Name of burial place		80. Name of burial place	
81. Name of burial place		82. Name of burial place		83. Name of burial place		84. Name of burial place		85. Name of burial place	
86. Name of burial place		87. Name of burial place		88. Name of burial place		89. Name of burial place		90. Name of burial place	
91. Name of burial place		92. Name of burial place		93. Name of burial place		94. Name of burial place		95. Name of burial place	
96. Name of burial place		97. Name of burial place		98. Name of burial place		99. Name of burial place		100. Name of burial place	

NOTED BY: 2/11/2011

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02176

2197

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 HR - 40 min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie Byrd				4. DATE OF DEATH Month February Day 2 Year 19 59			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/06	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas Chum				14. MOTHER'S MAIDEN NAME Sacki Haldin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sherman Husband		Address Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ss DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan. 20, 1959 , to Feb. 2, 1959 that I last saw the deceased alive on February 2, 1959 , and that death occurred at 3:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2724 74th Ave. DATE SIGNED							
ACTUAL SIGNATURE Till Bergman M.D.				PHYSICIAN'S NAME (Type) Dr. Till Bergman Hyattsville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2-6-59		22c. NAME OF CEMETERY OR CREMATORY Crestlinton		22d. LOCATION (City, town, or county) (State) Crestlinton Va	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington ADDRESS 467 N 4th NW				24a. REC'D BY REGISTRAR FEB 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1/1/5

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9, Film G240, 3/18/59 fcy
2198
CERTIFICATE OF DEATH

Reg. Dist. No.

02177

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
3. NAME OF DECEASED (Type or print) John First J. Middle Canty Lost		4. DATE OF DEATH Feb. 18 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1892
9. AGE (In years last birthday) 67 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME P.H. Canty		14. MOTHER'S MAIDEN NAME Mary A. Horrigan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.1		16. SOCIAL SECURITY NO. 577-50-6260	
17. INFORMANT Lillian E. Canty-wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451x Pulmonary edema DUE TO (b) Ruptured aortic aneurysm DUE TO (c) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 9, 1959, to Feb. 16, 1959, that I last saw the deceased alive on Feb. 16, 1959, and that death occurred at 1:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. C. Hageage		ADDRESS (Street, city or town, state) DATE SIGNED 3308 Perry St., Mt. Rainier, Md. 2/17/59	
PHYSICIAN'S NAME (Type) C. C. Hageage M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/19/59	
22c. NAME OF CEMETERY OR CREMATORY Arl Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lee's Sons Co.		24a. REC'D BY REGISTRAR 20 59	
ADDRESS 300-4th St. N.E.		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02178

2199

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/59</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>9</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>William J. Carter</u>		14. MOTHER'S MAIDEN NAME <u>Mary L.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary L. Carter</u>		Address <u>Mother</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cinoxia</u> <u>754.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Stenosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>February 9</u> , 19 <u>59</u> , to <u>February 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>February 11</u> , 19 <u>59</u> , and that death occurred at <u>8:50A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lois Mendel</u>		ADDRESS (Street, city or town, state) <u>4506 College Ave College Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Mendel</u>		DATE SIGNED <u>2/12/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/12, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REGD BY REGISTRAR <u>FEB 16 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED MARY ANN BROWN		SEX F		AGE 65	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION HOUSEWIFE		DATE OF DEATH JAN 15 1968	
TIME OF DEATH 10:30 AM		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE	
MEDICAL HISTORY HYPERTENSION		PRESENT ILLNESS HEART ATTACK		SIGNATURE OF PHYSICIAN J. H. Smith	
SIGNATURE OF NEXT OF KIN J. H. Smith		SIGNATURE OF DECEASED MARY ANN BROWN		SIGNATURE OF REGISTRAR J. H. Smith	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

02179

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1127 R. St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond B. Carver		4. DATE OF DEATH Month Day Year 2 3 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Shoreham Hotel	11. BIRTHPLACE (State or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles L. Carver		14. MOTHER'S MAIDEN NAME Marie J. Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 719-07-0349	17. INFORMANT Decedent Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, right lung 1621 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary tuberculosis, 15 years 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 16 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 11/30, 19 56, to 2/3, 19 59, that I last saw the deceased alive on 2/3, 19 59, and that death occurred at 10:00 AM, from the causes and on the date stated above.	
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 2/3/59	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) 2-7-59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) Washington, D.C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Joyner		ADDRESS 116 Massachusetts Ave. N. W.	
24a. REC'D BY REGISTRAR FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2200

CERTIFICATE OF DEATH

Reg. Dist. No.

02180

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges General</i>		d. STREET ADDRESS <i>14305 51 Street</i>	
3. NAME OF DECEASED (Type or print) <i>First Middle Last SR. ALFRED G. CHRONIGER</i>		4. DATE OF DEATH <i>February 27 19 59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/21/1956</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Building Bladens Naval Gun</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>Charles B. Chroniger</i>		14. MOTHER'S MAIDEN NAME <i>Mary J. Blackstone</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Elsie Mary - Address same - Wife</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-1</i> , 19 <i>54</i> , to <i>2-27</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>February 27, 19 59</i> , and that death occurred at <i>3P</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Aaron Deitz</i>		ADDRESS (Street, city or town, state) <i>Hyattsville, Md.</i> DATE SIGNED <i>2-27-59</i>	
PHYSICIAN'S NAME (Type) <i>Aaron Deitz</i>		M.D. <i>Hyattsville, Maryland</i>	
22a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/3/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor Pr. Geo. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		24a. REC'D BY REGISTRAR <i>MAR 4 59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. H. H.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2201

CERTIFICATE OF DEATH

Reg. Dist. No.

02181

1. PLACE OF DEATH a. COUNTY Prince Geo Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs Md. 1556.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial		d. STREET ADDRESS 14,106 Colesville Rd. 14106 Colesville Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bertha Va. Cisse 1		4. DATE OF DEATH Month 2 Day 8 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-81
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Alfred Scaggs		14. MOTHER'S MAIDEN NAME Sarah Frances Harding.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Record Office		Address 4408 Queensbury Rd Riverdale Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent pneumonia INTERVAL BETWEEN ONSET AND DEATH 5 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1959, to Feb 8, 1959, that I last saw the deceased alive on Feb 8, 1959, and that death occurred at 11 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John N. Andrews		ADDRESS (Street, city or town, state) 9601 Colesville Rd	
PHYSICIAN'S NAME (Type) John N. Andrews		DATE SIGNED 2-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/11/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Highland, Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE FEB 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

CERTIFICATE OF DEATH

PLACE OF DEATH COUNTY OF _____		DECEASED NAME _____	
DATE OF DEATH MONTH _____ DAY _____ YEAR _____		SEX _____	
TIME OF DEATH HOURS _____ MINUTES _____		AGE _____	
PLACE OF BIRTH COUNTY OF _____		DATE OF BIRTH MONTH _____ DAY _____ YEAR _____	
OCCUPATION _____		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	
MEDICAL HISTORY _____		PREVIOUS ILLNESS _____	
PHYSICIAN'S SIGNATURE _____		DEATH CERTIFICATE NO. _____	
COUNTY OF _____		CITY OF _____	
STATE OF NEW YORK		YEAR _____	

THIS CERTIFICATE IS VALID ONLY WHEN FILED IN THE OFFICE OF THE DEPARTMENT OF HEALTH, ALBANY, NEW YORK. IT IS NOT VALID IF FILED IN ANY OTHER OFFICE.

TO BE FILED IN THE OFFICE OF THE DEPARTMENT OF HEALTH, ALBANY, NEW YORK.

FILED IN THE OFFICE OF THE DEPARTMENT OF HEALTH, ALBANY, NEW YORK.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02182

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>DOG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Cedar Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>			d. STREET ADDRESS <u>916 64th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert Lee Clayton</u>			4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1957</u>	9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>5</u> Hours <u>15</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Robert Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Gwendolyn P. Clayton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother Same address as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John J. Maloney</u>		EXAMINER'S NAME (Type) <u>JOHN T. MALONEY - M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Feb. 8, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washburn</u>		ADDRESS <u>467 Nat W.W.</u>		24a. REC'D BY REGISTRAR <u>FEB 16 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2077234XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2203
CERTIFICATE OF DEATH

Reg. Dist. No.

02183

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 5502 Farragut Street			
3. NAME OF DECEASED (Type or print) First Middle Last Theodore Graham Coffey				4. DATE OF DEATH Month Day Year Feb. 3 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Dec. 1884		9. AGE (In years lost birthday) yrs. 74	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 1 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Equipment Sales		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Theodore Coffey				14. MOTHER'S MAIDEN NAME Nellie W. Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 289-01-7334		17. INFORMANT Theodore G. Coffey-son-same as 2d Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration & gastric contents (c) Acute pancreatic necrosis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-28 1959, to 2-3 1959, that I last saw the deceased alive on 2-3 1959, and that death occurred at 1:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George J Hageage M.D. 3717-38th St. Cottage City, Md. 2-3-59							
ACTUAL SIGNATURE George J Hageage				PHYSICIAN'S NAME (Type) George J Hageage			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/59		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02184

2204

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>2-11-59 11:00 AM</u> <u>2-17-59 5:45 PM</u>				d. STREET ADDRESS <u>Box 307 High Ridge Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Aloysius</u> Last <u>Cook</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-22-76</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - Night Watchman U.S. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Cook</u>				14. MOTHER'S MAIDEN NAME <u>Julia Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Mary A. Souder and Niece</u>				Address <u>Box 307 High Ridge Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral (Subdural Hematoma)</u> <u>904.0</u> DUE TO <u>Falling to head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u>Fall</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2-3-days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home striking back of head (Occiput)</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Laurel</u> <u>Howard</u> <u>Maryland</u>			
21. I certify that I attended the deceased from <u>9 January</u> , 19 <u>59</u> to <u>17 Feb</u> , 19 <u>59</u> that I last saw the deceased alive on <u>17 Feb</u> , 19 <u>59</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Feb 20, 1959</u>				22b. DATE THEREOF <u>Feb 20, 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem</u>				22d. LOCATION (City, town, or county) (State) <u>Seagoville Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. W. Coulter</u>				24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>			
ADDRESS <u>Laurel Md</u>				DATE <u>FEB 25 59</u>			

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2205

CERTIFICATE OF DEATH

Reg. Dist. No.

02185

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hosp</u>		d. STREET ADDRESS <u>16916-Defense Highway</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA M. CORY</u>		4. DATE OF DEATH <u>Feb 20 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Belgium</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Patteet</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Le Lore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Robert P. Cory</u>		Address <u>Marlboro, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMMORHAGE</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> DUE TO (c) <u>CARDIO-VASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hours</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1956</u> to <u>20 Feb 1959</u> , that I last saw the deceased alive on <u>20 Feb 1959</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4814-71st Ave.</u> DATE SIGNED <u>Thomas J. Maloney</u>			
ACTUAL SIGNATURE <u>Thomas J. Maloney</u> M.D.		PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY</u> <u>Woodlawn, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>Mt. Rainier</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. King</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2206

CERTIFICATE OF DEATH

Reg. Dist. No.

02186

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 4816 Meadow View e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Crombie				4. DATE OF DEATH Month 2 Day 21 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-19-1959	
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Bartholemew Crombie Jr.		14. MOTHER'S MAIDEN NAME Rosa Stewart		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Parents		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Asphyxiation DUE TO prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prematurity DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 2/19 to 2/21 , 19 59 , that I last saw the deceased alive on 2/21 , 19 59 , and that death occurred at 1:55 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE John Perkins				ADDRESS (Street, city or town, state) 5301 Hamlet St, Suitland, Md			
DATE SIGNED 2/22/59							
PHYSICIAN'S NAME (Type) Dr. John Perkins							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.				ADDRESS 317 Pa. Ave., SE DC3		24a. REC'D BY REGISTRAR 27 59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hays			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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DATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AF Base				c. LENGTH OF STAY IN 1b Washington 27			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS 4816 V Street S E			
3. NAME OF DECEASED (Type or print) First Middle Last Paul Matthew D'Antuono				4. DATE OF DEATH February 10 1959			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 August 1919	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY USAF Band		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matteo D'Antuono				14. MOTHER'S MAIDEN NAME Santa Norcio			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 41 - 45 577-16-5553		17. INFORMANT Official Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Wound Frontal of Head DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet self inflicted small arms weapon DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Small arms weapon placed against forehead			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Feb 10 1959 1028 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US Air Force Base	
				20f. (City or town) Andrews AFB, Washington D C		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1028 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10 Feb 59							
ACTUAL SIGNATURE Marvin E Haskin				M.D. USAF Hospital Andrews			
PHYSICIAN'S NAME (Type) MARVIN E HASKIN CAPT USAF (MC)				Andrews Air Force Base			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc. 816 H St. N.E. Wash. 2, D. C.				24a. REC'D BY REGISTRAR DATE FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Prince Georges County Coroner notified and approved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G239 2-20-59 et
2173
CERTIFICATE OF DEATH

Reg. Dist. No.

02188

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 mon 9days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis (Rural)		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rest Home 5801--42nd Ave., Hyattsville Conv.&	
d. STREET ADDRESS Route #1 Box # 2, Riva Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALVIN HENRY DAY		4. DATE OF DEATH February 13th, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3rd, 1869
9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Pressman		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Eng. & Printing	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Bideon Day		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Austin W. Day, 4821 Rhode Island Ave., Hyattsville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic changes in coronary arteries 10 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Prostata hypertrophy. Supra pubic cystotomy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-28 19 58, to 2-13 19 59, that I last saw the deceased alive on 2-13-59, 19, and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum		ADDRESS (Street, city or town, state) 6110--43rd Ave., Hyattsville, Md.	
DATE SIGNED 2/14/1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 17th, 1959	
22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Arlington Co., Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE FEB 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2207

CERTIFICATE OF DEATH

Reg. Dist. No.

02189

1. PLACE OF DEATH o. COUNTY <u>Prince George County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Handover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Franklin</u> Last <u>Dean</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-'78</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Dean Sr</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Juade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Dis</u> DUE TO (c) <u>3 MVO.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 24, 1959</u> to <u>Feb 5, 1959</u> , that I last saw the deceased alive on <u>Feb 5, 1959</u> , and that death occurred at <u>3:25</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin</u>				DATE SIGNED <u>2-5-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

HEAD OF STAFF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2208

CERTIFICATE OF DEATH

Reg. Dist. No.

02190

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 1/2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bowie d. STREET ADDRESS Highbridge Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ruth First R Middle DeBow Last		4. DATE OF DEATH Feb. Month 5 Day 1959 Year				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13 1907	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert J Roberts Sr.		14. MOTHER'S MAIDEN NAME Mabel L. Evans				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Husband Zacheus L De Bow Bowie, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cor. Cong. & Edemo. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction (c) Subacute occ. and des. G. left vent. Act. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2						INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/3 , 19 59 , to 2/5 , 19 59 , that I last saw the deceased alive on 2/4 , 19 59 , and that death occurred at 3:45A M, from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Harold J Kurtz M.D. RFD Bowie Md ADDRESS (Street, city or town, state) DATE SIGNED 2/5/59						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur P. K...

CERTIFICATE OF DEATH

2508

1940

<p>NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>DATE OF DEATH [Faint text, possibly "1940-10-15"]</p>	
<p>AGE [Faint text, possibly "45"]</p>		<p>SEX [Faint text, possibly "Male"]</p>	
<p>PLACE OF BIRTH [Faint text, possibly "Maryland"]</p>		<p>DATE OF BIRTH [Faint text, possibly "1900-05-01"]</p>	
<p>CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>DATE OF INTERMENT [Faint text, possibly "1940-10-17"]</p>		<p>PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>SIGNATURE OF REGISTRAR [Faint signature]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2174

CERTIFICATE OF DEATH

Reg. Dist. No.

02191

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5218 42th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ellen Last Denger		4. DATE OF DEATH Month February Day 8 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 5, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 8 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Norman N Hill		14. MOTHER'S MAIDEN NAME Alice Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Barbara D. Gibson		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE CEREBROVASCULAR HEMORRHAGE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 7 DAYS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 FEB. , 19 57 , to 8 FEB. , 19 59 , that I last saw the deceased alive on 3 FEB. , 19 59 , and that death occurred at 2:01 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 905 Cox AVE Hyattsville Md. DATE SIGNED 2/8/59			
ACTUAL SIGNATURE Henry R. Wolfe		M.D. 905 Cox AVE Hyattsville Md.	
PHYSICIAN'S NAME (Type) Henry R Wolfe		Hyattsville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/10/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR FEB 10 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur R. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2209

CERTIFICATE OF DEATH

Reg. Dist. No.

02192

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 7747 Frederick Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephen A Doyle				4. DATE OF DEATH Month February Day 6 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/01		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Stephen Doyle				14. MOTHER'S MAIDEN NAME Margaret Maxwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 402-18-8548		17. INFORMANT Amelia L Wife Address Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 582X DUE TO Atelue ta is both lower lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) App. gastric embolus (c) Renal abscess.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from January 18, 1959 , to February 6, 1959 , that I last saw the deceased alive on February 6, 1959 , and that death occurred at 8:50A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William B. Hagan M.D.				ADDRESS (Street, city or town, state) 3306 Rhode Island Ave. Mt. Ranier Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) William B. Hagan							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9th, 1959		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE FEB 10 59		24b. REGISTRAR'S SIGNATURE Arthur L. Hagan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State and at Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2252 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02193

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long Tan Store</u>		1. STREET ADDRESS <u>1021 - County Road</u>	
3. NAME OF DECEASED (Type or print) <u>Charlie C Dunlop</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 7, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier U.S.A. Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rockingham, North Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Frank S. Dunlop</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Grace Covington (sister)</u>	
17. INFORMANT <u>Charlotte, N.C.</u>		Address <u>417 Grandin Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>March 1, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-4-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEE FUNERAL HOME 300. 4th ST NE</u>		24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
KENTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2210

CERTIFICATE OF DEATH

Reg. Dist. No.

02194

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood d. STREET ADDRESS 4318 34th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Christian Middle Eckert Last Eckert		4. DATE OF DEATH Month February Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-73
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY steam & farmer	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lenhardt Eckert		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Helena Wilson Brentwood, Md.	
17. INFORMANT Helena Wilson		Address Brentwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized CARCINOMATOSIS 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) BRONCHIAL CARCINOMA DUE TO (c) 3 MONTHS		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-13-1959 to 2-14-1959 , that I last saw the deceased alive on 2-14-1959 and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert Roth		ADDRESS (Street, city or town, state) Riverdale, Md.	
PHYSICIAN'S NAME (Type) Dr. Albert Roth		DATE SIGNED 2-15-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/59	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR FEB 17 '59		24b. REGISTRAR'S SIGNATURE Arvin S. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

2010

1. Name of deceased: _____

2. Sex: _____

3. Date of birth: _____

4. Place of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Immediate cause of death: _____

9. Underlying cause of death: _____

10. Contributing causes: _____

11. Manner of death: _____

12. Signature of physician: _____

13. Signature of registrar: _____

14. Signature of informant: _____

15. Date of filing: _____



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in graveyards within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2211

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville		c. LENGTH OF STAY IN 1b 2½ years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3316 Lorin Drive			d. STREET ADDRESS 3316 Lorin Drive		
3. NAME OF DECEASED (Type or print) William Richard Edwards			4. DATE OF DEATH Month February Day 14 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/22		9. AGE (in years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ordinance Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy Yard		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME William Richard Edwards Sr.			14. MOTHER'S MAIDEN NAME Mattie Shields		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11 245-12-4458		17. INFORMANT Marion Edwards, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) Coronary atherosclerosis (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED February 15, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Barker Lewis		ADDRESS 1756 Penna. Ave., N.W.		24a. REC'D BY REGISTRAR DATE FEB 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

2

2

1.000 000

2011-10-10

FIG. 11.11

1. *Chlorophyll a*

• "The World's Largest Bookstore" •

13

3. The first two are the same as in the previous case.

0000000000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02196

2212

1. PLACE OF DEATH a. COUNTY Prince Geo MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.				c. LENGTH OF STAY IN 1b 8 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial - 4408 Greensbury Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marion First Virginia Middle Endt				4. DATE OF DEATH Month 2 Day 16 Year 19 59			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-26-1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby Sitter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Mr. Luther M. Slacum				14. MOTHER'S MAIDEN NAME Mary Va. Florence			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-12-6023		17. INFORMANT Address Hospital Records - 4408 Greensbury Rd. Riverdale	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage (b) General arteriosclerosis (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. INTERVAL BETWEEN ONSET AND DEATH 8 hrs undetermined							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 16, 1959, to Feb 16, 1959, that I last saw the deceased alive on Feb 16, 1959, and that death occurred at 7:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED 2-16-59 ACTUAL SIGNATURE L W Malin M.D. PHYSICIAN'S NAME (Type) L W Malin M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20, 1959		22c. NAME OF CEMETERY OR CREMATORY Belair Memorial		22d. LOCATION (City, town, or county) (State) Belair, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Loring Myers, 8728 Aberly Rd. Randallstown, Md.				24a. REC'D BY REGISTRAR DATE FEB 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2184

CERTIFICATE OF DEATH

Reg. Dist. No.

02197

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3809--31st Street				d. STREET ADDRESS 3809--31st Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHANNA Middle CONRAD Last ESLEY				4. DATE OF DEATH Month February Day 24th , Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4th, 1870	
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min.		IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Eppers				14. MOTHER'S MAIDEN NAME Betty (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Alba Donaldson, 3809--31st St. Mt. Rainier, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcers, hip & back---2 months				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May , 19 50 , to Feb. 24th , 19 59 , that I last saw the deceased alive on Feb. 23rd , 19 59 , and that death occurred at 2:45P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400--W--Street, N.E. Washington, D.C. DATE SIGNED Feb. 24th, 1959							
ACTUAL SIGNATURE Herbert G. Brandes				M.D. 400--W--Street, N.E. Washington, D.C.			
PHYSICIAN'S NAME (Type) Herbert G. Brandes							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27th, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR FEB 27 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2182

1918

PLACE TO DEATH		CAUSE OF DEATH	
HOSPITAL		DISEASE	
DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		OCCUPATION	
RELIGION		MILITARY SERVICE	
PREVIOUS ILLNESS		TREATMENT	
DIAGNOSIS		PATHOLOGICAL FINDINGS	
HISTORICAL DATA		LABORATORY TESTS	
FAMILY HISTORY		SOCIAL HISTORY	
PERSONAL HISTORY		LEGAL HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8

2175

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film G2393-2-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 02198

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>		d. STREET ADDRESS <u>327 E. Capitol St.</u> <u>MAY 22 / 1959</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Dudley</u> Last <u>FARRAN</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-78</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Farran</u>		14. MOTHER'S MAIDEN NAME <u>Martha Herbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>718-14-9311</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arterio-sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1958</u> to <u>Feb. 22, 1959</u> , that I last saw the deceased alive on <u>Feb. 21, 1959</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Brady</u>		DATE SIGNED <u>2/23/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony Hanlon</u>		24a. REC'D BY REGISTRAR DATE <u>2-22-59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>			

CERTIFICATE OF DEATH

2138

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>1910</i>	
5. PLACE OF BIRTH <i>London, England</i>		6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. PLACE OF DEATH <i>Home</i>	
9. DATE OF DEATH <i>1950</i>		10. TIME OF DEATH <i>10:00 AM</i>	
11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>30 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park 14</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>			d. STREET ADDRESS <u>5000-Hollywood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mary P. Fletcher</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>9th</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>	
13. FATHER'S NAME <u>William Sinclair</u>			14. MOTHER'S MAIDEN NAME <u>unknown Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>3927-35</u>		17. INFORMANT <u>Clyde D. Fletcher</u> <u>3927-35th St. Mt. Rainier, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion & edema</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric fracture of right femur</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in home</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> a.m. <u>1-10-</u> 1959	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>College Park - P. Geo. - Md</u>	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) <u>Switzland, Md.</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		ADDRESS <u>Mt. Rainier Md</u>		24a. REC'D BY REGISTRAR <u>11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Robert E. Kears</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
PUBLIC HEALTH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and printed form fields are visible. The form includes sections for patient information, cause of death, and examiner details.]

RECEIVED
BUREAU OF PUBLIC HEALTH
MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear of I. C. E. Club		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Leon Fones		4. DATE OF DEATH February 28 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 13, 1900 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Letter Carrier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Post Office	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Fones		14. MOTHER'S MAIDEN NAME Mae I. Boyd Travis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW L		16. SOCIAL SECURITY NO. 3321	
17. INFORMANT Mrs Florence Valitine Washington		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 9777 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Severance of arteries of both wrists (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cut wrists with a razor blade	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cut wrists with a razor blade	
20c. TIME OF INJURY Month, Day, Year 2/28/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Place of death		20f. (City or town) Morningside (County) P. G. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED February 28, 1959	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-1959	
22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		22d. LOCATION (City, town, or county) (State) Suitland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
24b. REGISTRAR'S SIGNATURE Carlton L. Kneib			

MEDICAL CERTIFICATION

2

C

1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2176

CERTIFICATE OF DEATH

Reg. Dist. No.

02201

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b July 3, 1958			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,			
				d. STREET ADDRESS 14709 Carrollton Road			
3. NAME OF DECEASED (Type or print) First Middle Last Male S. GALLAGHER				4. DATE OF DEATH Month Day Year Feb. 8 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Full				14. MOTHER'S MAIDEN NAME Anna Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Mary G. Grady, 14709 Carrollton Rd., Rockville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarctus 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 21 days 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Dec 21 19 58 , to Feb 8 19 59 , that I last saw the deceased alive on Feb 7 19 59 , and that death occurred at 6:00 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Collins M.D.				ADDRESS (Street, city or town, state) 384 H NE		DATE SIGNED 2-8-59	
PHYSICIAN'S NAME (Type) THOMAS F. COLLINS MD Washington DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 10, 1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Raymond A. Ziska			ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR FEB 10 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

Reg. Dist. No.

02202

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Rd.</u> <u>08X-2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>		d. STREET ADDRESS <u>Bryans Rd. Trailer Pk, Lot # 31.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Timothy Wayne GEDDES</u>		4. DATE OF DEATH Month Day Year <u>Feb 4 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11, 1951</u>
9. AGE (In years lost birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>New Orleans, La</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George C. Geddes</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Brickley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Mrs Alice Brickley Daley (M) Trailer Pk, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>053.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Overwhelming Septicemia</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 Hr Nomin</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4 Feb</u> , 19 <u>59</u> , to <u>4 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 Feb</u> , 19 <u>59</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USAF Hospital Andrews</u> <u>4 February 1959</u>			
ACTUAL SIGNATURE <u>Vincent P. Ringrose Jr</u> M.D.		PHYSICIAN'S NAME (Type) <u>Vincent P Ringrose Jr Capt USAF (MC) Andrews AFB, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>FEB. 6, 1959</u>	<u>ARLINGTON NATIONAL</u>	<u>ARLINGTON VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>RINALDI FUNERAL HOME 816 H St. N.E. Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

Medical Examiner notified and approved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02203

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9000 51th avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle E. Last Gilbert		4. DATE OF DEATH Month Feb Day 14 , Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 2, 1864
9. AGE (In years last birthday) yrs. 94		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs L H Hill		Address 9223 Longbranch Parkway Silver Springs, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate		INTERVAL BETWEEN ONSET AND DEATH 6 hr. 30 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1958 to 2-14 , 1959, that I last saw the deceased alive on 2-13 , 1959, and that death occurred at 11:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2513 Brookledge Rd. Adelphi Md. DATE SIGNED 2/14/59			
ACTUAL SIGNATURE R.D. Bauer M.D.		PHYSICIAN'S NAME (Type) R.D. Bauer M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 2/16/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mc Pleasant Cemetery		22d. LOCATION (City, town, or county) (State) Genera, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE FEB 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2255

CERTIFICATE OF DEATH

Reg. Dist. No.

02204

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE (RURAL)		c. LENGTH OF STAY IN 1b 14 7 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILBERT Middle W. Last GRISSOM		4. DATE OF DEATH Month FEB. Day 1 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/14
9. AGE (In years lost birthday) 44 yrs.		IF UNDER 1 YEAR Months 4 Days — Hours — Min. —	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BALLIE H. GRISSOM		14. MOTHER'S MAIDEN NAME SALLIE H. DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 237-22-0478	
17. INFORMANT DECEASED		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 7 yrs 3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA 14 7 hrs			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/10 , 19 57 , to 2/1 , 19 59 , that I last saw the deceased alive on 1/31 , 19 59 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Woe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 2/1/59	
PHYSICIAN'S NAME (Type) MOE WEISS M.D.		Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/1/59	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Bedderson, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, Jr.		ADDRESS 4401 Choptank Rd.	24a. REC'D BY REGISTRAR — DATE FEB 4 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kinn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2159

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2214

CERTIFICATE OF DEATH

Reg. Dist. No.

02205

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 2 Hr.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince General Hospital		d. STREET ADDRESS 11500 Cedar Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Clarence E. HAGEN (Hagin)		4. DATE OF DEATH Feb. 4 Day Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1922
9. AGE (In years last birthday) 36		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Biochemist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't Plant Industry	11. BIRTHPLACE (State or foreign country) Lake Park, Minn.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clarence E. Hagen	
14. MOTHER'S MAIDEN NAME Irene Charlotte Ebeltoft		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II	
16. SOCIAL SECURITY NO. 502-10-5222		17. INFORMANT Address Colleen M. Hagen, 11500 Cedar Lane, Beltsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 12 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from Jan 2-4, 1959 to 2-4-59 , 19 59 , that I last saw the deceased alive on Feb. 4 , 19 59 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr Albert Roth		ADDRESS (Street, city or town, state) Riverdale	
PHYSICIAN'S NAME (Type) Dr Albert Roth		DATE SIGNED 2-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9th, 1959	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. P... ..			

F. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2256

CERTIFICATE OF DEATH

02206

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights		c. LENGTH OF STAY IN b 11 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5610 Ruatan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle BENNETT Last HALEY		4. DATE OF DEATH February 12th, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21st, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Kent Store, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mary E. Haley, 5610 Ruatan St. Berwyn Hgts., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Arteriosclerosis of cerebral arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cerebro-vascular disease DUE TO Hypertensive cerebro-vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 several years several years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1st , 19 57 , to Feb. 12th , 19 59 , that I last saw the deceased alive on 2-7- , 19 59 , and that death occurred at 4:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN ST. DATE SIGNED ACTUAL SIGNATURE Till Bergemann M.D. PHYSICIAN'S NAME (Type) TILL BERGEMANN, M.D. HYATTSVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 16th, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE FEB 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2257

CERTIFICATE OF DEATH

Reg. Dist. No.

02207

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Mass.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Base				c. LENGTH OF STAY IN TB 7 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 20, D.C.				S.E. 58X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) USAF Hospital Andrews				d. STREET ADDRESS 1066 Barnaby Terrace			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Eric Middle David Last Harding				4. DATE OF DEATH Month February Day 22 Year 19 59			
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 February 1959	
9. AGE (In years last birthday) ----- yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard D. Harding				14. MOTHER'S MAIDEN NAME Mother-Thelma Madeleine Warner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) N/A (If yes, give war or date of service) N/A				16. SOCIAL SECURITY NO. N/A			
17. INFORMANT Father-Richard D. Harding				1066 Barnaby Terr. SE Washington 20, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular-pulmonary collapse DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 15 February, 19 59, to 22 February, 19 59, that I lost s/he the deceased olive on 22 February, 19 59, and that death occurred at 1215P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSPITAL ANDREWS, AAFB, 25 DC 22FEB59 M.D. JOHN A MOORE CAPT USAF(MC) USAF HOSPITAL ANDREWS, AAFB, 25 DC 22FEB59 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME 816 H ST. N.E. NASH DC.				24a. REC'D BY REGISTRAR FEB 26 '59		24b. REGISTRAR'S SIGNATURE	

2050231XV2

CERTIFICATE OF DEATH

File No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
JAMES E. DUNN		Male		45		1880		Maryland		Farmer		Heart Disease		Home		10:00 AM		J. E. Dunn		J. E. Dunn		J. E. Dunn	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF BURIAL		21. NAME OF CREMATION		22. NAME OF URN		23. NAME OF CASK		24. NAME OF COFFIN	
St. John's Church		St. John's Church		10/10/1925		J. E. Dunn		St. John's Church		J. E. Dunn		St. John's Church		St. John's Church		St. John's Church		St. John's Church		St. John's Church		St. John's Church	



CHIEF CLERK

CERTIFICATE OF DEATH

02208

Reg. Dist. No.

2258

1. PLACE OF DEATH a. COUNTY Prince Georges				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland				b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indianhead				08X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS 26J Riverview Village				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Adam David Heffelfinger				4. DATE OF DEATH Month Day Year February 25 1959											
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 October 1918		9. AGE (In years last birthday) yrs. 40		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman				10b. KIND OF BUSINESS OR INDUSTRY USAF				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Adam David Heffelfinger				14. MOTHER'S MAIDEN NAME Verna Dorothy Leber											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II				17. INFORMANT Official Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracranial hemorrhage 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 Hours 10 Days															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 25 February, 1959, to 25 February, 1959, that I lost saw the deceased olive on 25 February, 1959, and that death occurred at 7:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital Andrews 25 Feb 59 ACTUAL SIGNATURE Sanford L Billett M.D. PHYSICIAN'S NAME (Type) SANFORD L BILLETT CAPT USAF (MC) Andrews AFB, Wash 25, D. C.															
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF MARCH 2, 1959		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL				22d. LOCATION (City, town, or county) (State) ARLINGTON VA					
23. FUNERAL DIRECTOR'S SIGNATURE KINARDI FUNERAL HOME						ADDRESS 816 H ST. N.E., WASH		24a. REC'D BY REGISTRAR DATE FEB 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2215
CERTIFICATE OF DEATH

Reg. Dist. No.

02209

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Month 9Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 7422 Taylor St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsa First Hoelk Middle Last		4. DATE OF DEATH Month Feb. Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1900 9. AGE (In years last birthday) yrs. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Karl Meyer		14. MOTHER'S MAIDEN NAME Anna Schawanemann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hans C Hoelk		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 Branch pneumonia DUE TO (b) Myelogenous leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 204.1			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-1 19 50 to 2-19 19 59 , that I last saw the deceased alive on 2-18 19 59 , and that death occurred at 9:40A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 Gallan St. Hyattsville, Md. DATE SIGNED Feb 24 '59			
ACTUAL SIGNATURE Dr. Aaron Dietz		M.D. 4314 Gallan St. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2/21/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE FEB 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

Case No.

Age

Sex

Color

Marital

Occupation

Place of Birth

Place of Death

Time of Death

Cause of Death

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1 **FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02210

Reg. Dist. No.

1. PLACE OF DEATH Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY in lb D. O. A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 4111 Nicholson St. Apt. # 5	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) RONALD First LEON Middle JACKSON Last		4. DATE OF DEATH Month Feb. Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1958
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months 7 Days 7	IF UNDER 24 HRS. Hours 7 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold W. Jackson		14. MOTHER'S MAIDEN NAME Sandra H. DeShazo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harold W. Jackson.		Address Same as # 2 (Father)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobar pneumonia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED 2/10/59	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2/12/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	22d. LOCATION (City, town, or county) (State) Suitland Md
23. FUNERAL DIRECTOR'S SIGNATURE J. Wan Lee's SinoC		24. REC'D BY REGISTRAR 300-4th St N.E.	
24a. REGISTRAR'S SIGNATURE Feb 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

NAME OF DECEASED: JACKSON, JOHN
AGE: 45
SEX: Male
RACE: White

DATE OF DEATH: July 1, 1958
PLACE OF DEATH: Jackson, Mississippi

CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural

DECEASED'S RESIDENCE: Jackson, Mississippi
DECEASED'S OCCUPATION: Farmer

DECEASED'S BIRTH DATE: July 1, 1913
DECEASED'S BIRTH PLACE: Jackson, Mississippi

DECEASED'S MARRIAGE STATUS: Married
DECEASED'S SPOUSE'S NAME: Mary Jackson

DECEASED'S EDUCATION: High School Graduate
DECEASED'S RELIGION: Baptist

DECEASED'S SOCIAL SECURITY NUMBER: [REDACTED]
DECEASED'S MARITAL STATUS: Married

DECEASED'S PREVIOUS MARRIAGES: None
DECEASED'S PREVIOUS SPOUSES: None

DECEASED'S PREVIOUS DEATHS: None
DECEASED'S PREVIOUS CAUSES OF DEATH: None

DECEASED'S PREVIOUS MANNER OF DEATH: None
DECEASED'S PREVIOUS MANNER OF DEATH: None

DECEASED'S PREVIOUS RESIDENCES: None
DECEASED'S PREVIOUS RESIDENCES: None

DECEASED'S PREVIOUS OCCUPATIONS: None
DECEASED'S PREVIOUS OCCUPATIONS: None

DECEASED'S PREVIOUS EDUCATION: None
DECEASED'S PREVIOUS EDUCATION: None

DECEASED'S PREVIOUS RELIGION: None
DECEASED'S PREVIOUS RELIGION: None

DECEASED'S PREVIOUS SOCIAL SECURITY NUMBER: None
DECEASED'S PREVIOUS SOCIAL SECURITY NUMBER: None

DECEASED'S PREVIOUS MARRIAGE STATUS: None
DECEASED'S PREVIOUS MARRIAGE STATUS: None

DECEASED'S PREVIOUS SPOUSE'S NAME: None
DECEASED'S PREVIOUS SPOUSE'S NAME: None

DECEASED'S PREVIOUS EDUCATION: None
DECEASED'S PREVIOUS EDUCATION: None

DECEASED'S PREVIOUS RELIGION: None
DECEASED'S PREVIOUS RELIGION: None

DECEASED'S PREVIOUS SOCIAL SECURITY NUMBER: None
DECEASED'S PREVIOUS SOCIAL SECURITY NUMBER: None

DECEASED'S PREVIOUS MARRIAGE STATUS: None
DECEASED'S PREVIOUS MARRIAGE STATUS: None

DECEASED'S PREVIOUS SPOUSE'S NAME: None
DECEASED'S PREVIOUS SPOUSE'S NAME: None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2217 CERTIFICATE OF DEATH

02211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 38			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital				d. STREET ADDRESS Rural			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Richard ^{First} Raymond ^{Middle} Jacoby ^{Last}				4. DATE OF DEATH Month Feb Day 10 Year 19 59					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/9/1902		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed				10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Uniontown Pa		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Robert Jacoby				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Lillian Jacoby Address Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Occlusion with DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized arteriosclerosis DUE TO (b) few years (c) years </div> <div style="width: 15%; text-align: right;"> INTERVAL BETWEEN ONSET AND DEATH few hours </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/20 , 19 58 , to 2/10 , 19 59 , that I last saw the deceased alive on 2/9 , 19 59 , and that death occurred at 355 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) R F D Bowie Md DATE SIGNED 4/10/59									
ACTUAL SIGNATURE H. James Kurtz M.D.				ADDRESS R F D Bowie, Md.					
PHYSICIAN'S NAME (Type) H. James Kurtz				ADDRESS R F D Bowie, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/59		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery			22d. LOCATION (City, town, or county) (State) Washington D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.				24a. REC'D BY REGISTRAR FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1910		Alabama	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Farmer		High School		Methodist	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
1950		10:00 AM		Home		Dr. Smith		None	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>	
c. LENGTH OF STAY IN 1b <u>37 years</u>		d. STREET ADDRESS <u>16411 S. St. Cedar Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16411 S. St. Cedar Heights</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Flota</u> First <u>Howard</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH <u>2</u> Month <u>6</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 16, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Edward Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Daughter (Mary Johnson)</u> Address <u>6411 S. St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 week</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John G. Todd</u> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Todd M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/19/59</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Oak Grove.</u>	
22c. LOCATION (City, town, or county) <u>Mt. Zion, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Saunden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE, IN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Death: [illegible]
5. Place of Death: [illegible]
6. Cause of Death: [illegible]
7. Manner of Death: [illegible]
8. Signature of Medical Examiner: [illegible]
9. Date of Examination: [illegible]
10. [illegible]
11. [illegible]
12. [illegible]
13. [illegible]
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97. [illegible]
98. [illegible]
99. [illegible]
100. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2218

CERTIFICATE OF DEATH

02213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN 1b 28 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jefferson Johnson Sr.		4. DATE OF DEATH Month February Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/12/70
9. AGE (In years last birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farman for D.C. Gov. D.C. S.V. Emp	
11. BIRTHPLACE (State or foreign country) Cloud Va		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Willy Johnson		14. MOTHER'S MAIDEN NAME Polly Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Jefferson Jr. 5812 L st. Fairmont Hgts.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **C. H. F.**

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b) **A. S. H. D Ca of prostate with**
(c) **generalised metastasis**

INTERVAL BETWEEN ONSET AND DEATH

8-12 weeks**5 years**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from **1.31.59**, 19____, to **2.2**, 19**59** that I last saw the deceased alive on **February 2**, 19**59**, and that death occurred at **12:58A**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

William D. Rosson M.D.

PHYSICIAN'S NAME (Type)

William D. Rosson, M.D. - 5304 Annapolis Rd., Bladensburg, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE WHEREOF 2/2/59	22c. NAME OF CEMETERY OR CREMATORY Clond Va	22d. LOCATION (City, town, or county) (State) Cloud Va
23. FUNERAL DIRECTOR'S SIGNATURE Shirley Funeral Home		24a. REC'D BY REGISTRAR DATE FEB 11 '59	24b. REGISTRAR'S SIGNATURE Shirley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

William Johnson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2219

CERTIFICATE OF DEATH

02214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle H. Last Johnson				4. DATE OF DEATH Month Feb. Day 19 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/14/68	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook - Railroad				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. lost		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 002X IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 8 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY FIBROSIS + EMPHYSEMA; CEREBRAL ARTERIO SCLEROSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/4 , 19 59 , to 2/19 , 19 59 , that I last saw the deceased alive on February 19, 1959 , and that death occurred at 2:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital, Glenn Dale, Maryland DATE SIGNED 2/19/59 ACTUAL SIGNATURE Moe Weiss PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/59		22c. NAME OF CEMETERY OR CREMATORY Barbur Fun. Home 485 N. WEDD		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Barbur Fun. Home				24a. REC'D BY REGISTRAR DATE FEB 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2177 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film G239 3-9-59 et
CERTIFICATE OF DEATH

Reg. Dist. No.

02215

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 2 yrs +	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Josephine Last Kean		4. DATE OF DEATH Month Feb. Day 24 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1870
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant LIBRARIAN		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. of Comm.	
11. BIRTHPLACE (State or foreign country) Charlestown, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Maurice Kean		14. MOTHER'S MAIDEN NAME Mary Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Home RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Hypertension + Arteriosclerosis Heart Failure DUE TO (c) Preliminary Impression		INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 10 , 19 58 , to Feb 24 , 19 59 , that I last saw the deceased alive on Feb 23 , 19 59 , and that death occurred at 7:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3066 - Que St. N.W. Wash. D.C. DATE SIGNED Arthur L. Kean			
ACTUAL SIGNATURE Arthur L. Kean M.D.		PHYSICIAN'S NAME (Type) E. Stuart Lyddane, M.D. 3066 Que St., NW, Wash. DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-26-59	
22c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY		22d. LOCATION (City, town, or county) (State) BOLIVAR HEIGHTS HARPERS FERRY W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don DeVol ADDRESS 2224 - Wis. Ave. Washington 7 DC		24a. REC'D BY REGISTRAR MAR 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kean			

CERTIFICATE OF DEATH

13-77

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF OFFICIAL	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2260 Item 9 Film G240 3-19-59 et CERTIFICATE OF DEATH

Reg. Dist. No.

02216

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, Andrews AFB				d. STREET ADDRESS 2423 Minnesota Ave S E			
3. NAME OF DECEASED (Type or print) First Middle Last Frederick NMI KNOPF				4. DATE OF DEATH Month Day Year February 20 19 59			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 October 1893	9. AGE (In years last birthday) 199 65 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Glazer		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Knopf				14. MOTHER'S MAIDEN NAME Emily Muth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 578-01-7444		17. INFORMANT Jack B Knopf Address 2423 Minnesota Ave Wash D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 Auricular fibrillation and Pneumonia, bilateral DUE TO (b) Arteriosclerotic heart disease with congestive failure 7 Days DUE TO (c) Pulmonary emphsema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 February, 19 59, to 20 February 19 59, that I last saw the deceased alive on 20 February 19 59, and that death occurred at 8:20 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Heino Trees</i>				ADDRESS (Street, city or town, state) USAF Hospital Andrews		DATE SIGNED 20 Feb 59	
PHYSICIAN'S NAME (Type) HEINO TREES				Andrews AFB, Washington 25 D C			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-59		22c. NAME OF CEMETERY OR CREMATORY Carl. Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Regis A. Walsh - 741-11th St. S. E.</i>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Regis A. Walsh</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2220

CERTIFICATE OF DEATH

02217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louis First Middle Last		4. DATE OF DEATH Feb. 12 19 59 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 9, 1899
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Tax assement		10b. KIND OF BUSINESS OR INDUSTRY Pro George's Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Harry Kutsch		14. MOTHER'S MAIDEN NAME Amelia Crozier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-03-9125	
17. INFORMANT Wilner Louis Kutsch, Son		Address Ardmore .Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rh. pul. emboli 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infar. left (c) Art. sclerotic Ht de.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-10 , 19 40 , to 2-12 , 19 59 , that I last saw the deceased alive on Feb. 12 , 19 59 , and that death occurred at 2:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A Deitz		DATE SIGNED 2-12-59	
PHYSICIAN'S NAME (Type) A Deitz		ADDRESS (Street, city or town, state) Hyattsville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/14/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2261 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. LENGTH OF STAY IN TB <u>2 mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Lane</u>		d. STREET ADDRESS <u>Cherry Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Michael Wendell Lewis</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5, 1958</u>
9. AGE (In years last birthday) <u>2</u> yrs. <u>13</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>		13. FATHER'S NAME <u>Richard Vincent Lewis</u>	
14. MOTHER'S MAIDEN NAME <u>Jean Johnson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Jean Lewis, same as #2</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause lost. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Feb 17, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-20-59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Arden stn</u>	22d. LOCATION (City, town, or county) (State) <u>It mayr Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hugh S. Washington</u> ADDRESS <u>467 N st N.W.</u>		24a. REC'D BY REGISTRAR <u>Feb 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

MEDICAL CERTIFICATION

2050242XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2221

CERTIFICATE OF DEATH

02219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 5714 J. St. N.E. Washington, D.C. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle A. Last Linkins				4. DATE OF DEATH Month Feb. Day 9 Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/ 4/ 91	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Mail Worker				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James A. Linkins				14. MOTHER'S MAIDEN NAME Nora Simmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Dolly L. Prince, Sister, 446 Washington, D.C.				Address 4511 J N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, circulatory 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) failure DUE TO (c) myocardial infarction. INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 8 , 19 59 , to Feb 9 , 19 59 , that I last saw the deceased alive on Feb. 9 , 19 59 , and that death occurred at 4:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3308 Perry St. Mt. Rainier, Md. DATE SIGNED 2/9/59 ACTUAL SIGNATURE Charles C. Hageage PHYSICIAN'S NAME (Type)							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
2-14-59		2-14-59		Lincoln Memorial Cemetery		P. S. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews				ADDRESS 3619-14 St NW		24a. REC'D BY REGISTRAR FEB 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. [illegible]		Male		45		[illegible]		[illegible]	
Occupation		Cause of Death		Date of Death		Place of Death		Time of Death	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
Signature of Physician		Signature of Registrar		Signature of [illegible]		Signature of [illegible]		Signature of [illegible]	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2222

CERTIFICATE OF DEATH

Reg. Dist. No.

02220

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier d. STREET ADDRESS 1 4109 34th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) George		First George		Middle F.		Last Little		4. DATE OF DEATH Month Feb.		Day 12		Year 1959	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-4-1876		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82		IF UNDER 24 HRS. Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Ret. Wash, Navy, Philadelpha, Pa.								10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Isaac Little				14. MOTHER'S MAIDEN NAME Amy Hall				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Paul E. Wright				Address above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarct 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple & Cerebral Edema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1952 , 19____, to 2/12 , 19 59 , that I last saw the deceased alive on 2/12 , 19 59 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7206 Colver Rd. DATE SIGNED ACTUAL SIGNATURE Leon R. Gallen M.D. W. H. Galt Med. PHYSICIAN'S NAME (Type) Dr. Leon Gallen													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery				22d. LOCATION (City, town, or county) (State) Washington D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home				ADDRESS Mt. Rainier, Md.				24a. RECEIVED BY REGISTRAR DATE FEB 18 59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01 Oct 2001

[illegible]

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02226

2262

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ammendale		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammendale Normal Institute		d. STREET ADDRESS Ammendale Normal Institute	
3. NAME OF DECEASED (Type or print) Brother Galbert Lucian (Patrick McGurk)		4. DATE OF DEATH February 4th, Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20th, 1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Christian Brother		10b. KIND OF BUSINESS OR INDUSTRY Religious Order	
11. BIRTHPLACE (State or foreign country) Derry County, Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hugh McGurk		14. MOTHER'S MAIDEN NAME Latitia McGee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records--Ammendale Normal Institute		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V-Rhine 20 yrs (c) Gen. Arteriosclerosis 20 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis INTERVAL BETWEEN ONSET AND DEATH 10 days 20 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/15 , 19 52 to 2/4 , 19 59 , that I last saw the deceased alive on 2/3 , 19 59 , and that death occurred at M , from the cause and on the date stated above. ADDRESS (Street, city or town, state) Laurel DATE SIGNED 2/4/59 ACTUAL SIGNATURE J. M. Warren M.D. Laurel PHYSICIAN'S NAME (Type) J. M. Warren			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6th, 1959	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Ammendale Normal Institute Baltimore P.O., Prince Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraw			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02221

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PG</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>	
c. LENGTH OF STAY IN 1b <u>Neolmanil</u>		d. STREET ADDRESS <u>4425 South River Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prinzel Georges Jones Hosp.</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) <u>Ernest George Lumb</u>		4. DATE OF DEATH <u>Feb 27 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20 1881</u>
9. AGE (In years last birthday) <u>77</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prof Reader Richard</u>		12. BIRTHPLACE (State or foreign country) <u>England</u>	
13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. FATHER'S NAME <u>John Lumb</u>	
15. MOTHER'S MAIDEN NAME <u>Ellen Colley</u>		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
17. SOCIAL SECURITY NO. <u>UNK</u>		18. INFORMANT <u>RR Block, same as #2</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>Feb 27 1959</u>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematorium</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>MAR 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2222

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



NAME OF DECEASED: *John Doe*
AGE: *45* SEX: *M*
DATE OF DEATH: *Jan 15 1912*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF EXAMINER: *J. H. Smith*
OFFICE OF EXAMINER: *State Health Dept.*

John Doe

2224

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook Md				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9437 Washington Ave.				/d. STREET ADDRESS 9437 Washington ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Olga Emma Matilda May				4. DATE OF DEATH Month February Day 11 , Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Berlin Germany	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Henry R May Kensington Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident (Thrombosis) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Oct 1938 years years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Manth. Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/21, 1959 , to 2/11, 1959 , that I last saw the deceased alive on 2/10, 1959 , and that death occurred at 10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James Kurtz M.D.				DATE SIGNED R F D Baile			
PHYSICIAN'S NAME (Type) H. James Kurtz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE FEB 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2225

CERTIFICATE OF DEATH

Reg. Dist. No.

02223

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. STREET ADDRESS Lanham Severn Road	
3. NAME OF DECEASED (Type or print) James S Mc Bride		4. DATE OF DEATH Month Feb Day 15 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 21, 1914
9. AGE (In years last birthday) yrs. 44		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purching Agent		10b. KIND OF BUSINESS OR INDUSTRY Southern Oxygen Co	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Smith Mc Bride		14. MOTHER'S MAIDEN NAME Irene Cottrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577 12 9464	
17. INFORMANT Hospital record		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary-Sclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956, to 2/15, 1959, that I last saw the deceased alive on 2-12, 1959, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Albert Roth M.D. Riverdale 2-15-59 PHYSICIAN'S NAME (Type) Albert Roth Riverdale Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR DATE FEB 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Tward	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of Health Officer		15. Signature of County Clerk	
16. Signature of State Registrar		17. Signature of State Coroner		18. Signature of State Medical Examiner		19. Signature of State Health Officer		20. Signature of State County Clerk	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2178

02224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 1 1/2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice McDermott		4. DATE OF DEATH February 2, 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1869
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR: Months 2 Days 2 Hours 19 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11b. KIND OF BUSINESS OR INDUSTRY Scotland	
12. BIRTHPLACE (State or foreign country) Scotland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME John M c Dermott		15. MOTHER'S MAIDEN NAME Mary Toule	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. Angela Fitzgerald; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED February 2, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-1959	
22c. NAME OF CEMETERY OR CREMATORY Wash D C		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Mattingly		24. REC'D BY REGISTRAR Arthur L. Kline	
ADDRESS 131-11 St		DATE FEB 4 '59	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

TIME

PLACE

DATE

TIME

PLACE

CAUSE

PLACE

TIME

PLACE

CAUSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02225

2226

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruby First Middle Last C. Mc Gibbon		4. DATE OF DEATH Feb. 15 Month Day Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Fees		14. MOTHER'S MAIDEN NAME Isabel Sheets	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT David A Mc Gibbon		Address Melbourne Florida.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 260x DUE TO DIABETIC ACIDOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETES MELLITUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 days 25 days 20 years
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1953 to 2-15-59 , that I last saw the deceased alive on 2-14-59 , and that death occurred at 8:35 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis Road, Lanham, Md. DATE SIGNED ACTUAL SIGNATURE Albert Roth M.D. PHYSICIAN'S NAME (Type) Dr. Albert Roth			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR FEB 17 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

CERTIFICATE OF DEATH

2222

FILE NO.

DATE

DECEASED

DATE OF DEATH

PLACE

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

EDUCATION

DATE OF MARRIAGE

NAME

DATE OF INTERVIEW

INTERVIEWER

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERVIEW

INTERVIEWER

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERVIEW

INTERVIEWER

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERVIEW

INTERVIEWER



Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/SS

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2263

02228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>		c. LENGTH OF STAY IN 1b <u>8 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Hillcrest Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2300 Jameson Street</u>				d. STREET ADDRESS <u>2300 Jameson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Dwight</u> Last <u>McLaughlin</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>coffee manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>coffee manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Joseph John McLaughlin</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Mize</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4809-01278</u>		17. INFORMANT <u>Joseph J. McLaughlin</u>		Address <u>Baltimore</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heabates</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Feb 19, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>2/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Co</u>				ADDRESS <u>300- 4th St N.E. Wash D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. Smith</u>							

NOT FOR
PUBLIC
USE

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Cause of Death: _____

10. Manner of Death: _____

11. Signature of Medical Examiner: _____

12. Signature of Coroner: _____

13. Signature of Registrar: _____

14. Signature of Physician: _____

15. Signature of Nurse: _____

16. Signature of Other: _____

1 ~~8~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2179 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Hyattsville Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4112 Queensbury Road		e. STREET ADDRESS 4112 Queensbury Road	
3. NAME OF DECEASED (Type or print) Oscar First Emil Middle Messerschmidt Last		4. DATE OF DEATH Month Feb Day 2 Year 19 59-	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool and Die maker		10b. KIND OF BUSINESS OR INDUSTRY Gischner Iron Works	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany <input checked="" type="checkbox"/>	
13. FATHER'S NAME August Messerschmidt		14. MOTHER'S MAIDEN NAME Clara Hesse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Liddy Messerschmidt		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion. (c) 420.1 DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 2, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 6, 1959	22c. NAME OF CEMETERY OR CREMATOR George Washington	22d. LOCATION (City, town, or county) (State) Hyattsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR FEB 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2264

CERTIFICATE OF DEATH

02230

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Ritchie				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7700 Whitehouse Rd., S.E.				d. STREET ADDRESS 7700 Whitehouse Rd., S.E.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Maude Middle A. Last Moore				4. DATE OF DEATH Month Feb. Day 20, Year 19 59.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1905		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tenant Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Windsor				14. MOTHER'S MAIDEN NAME Mary Windsor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Leonard Moore---same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum with metastases 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) none of note							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural causes					
20c. TIME OF INJURY Hour o. m. p. m. — 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from Feb 16, 1957 to Feb 20, 1959 , that I last saw the deceased alive on Feb 20, 1959 , and that death occurred at 5:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5440 Silver Hill Rd SE Washington 25 DC DATE SIGNED 2/20/59:							
ACTUAL SIGNATURE Paul C. Van Natta		M.D. 5440 Silver Hill Rd SE Washington 25 DC					
PHYSICIAN'S NAME (Type) PAUL C. VAN NATTA		Washington 25 DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/23/59	22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) Forestville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR FEB 25 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Murray		4. DATE OF DEATH February 25 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY General	
13. BIRTHPLACE (State or foreign country) Unknown		14. CITIZEN OF WHAT COUNTRY U. S. A.	
15. FATHER'S NAME Unknown		16. MOTHER'S MAIDEN NAME Unknown	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		18. SOCIAL SECURITY NO.	
19. INFORMANT		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED February 27, 1959	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-27-59	22c. NAME OF CEMETERY OR CREMATORY K. Grand Med. School	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE MAR 3 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Knead	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
1922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH BOARD

1. NAME OF DECEASED
2. AGE
3. SEX
4. RACE
5. OCCUPATION
6. PLACE OF BIRTH
7. DATE OF BIRTH
8. DATE OF DEATH
9. PLACE OF DEATH
10. CAUSE OF DEATH
11. MANNER OF DEATH
12. SIGNATURE OF EXAMINER
13. SIGNATURE OF WITNESSES
14. SIGNATURE OF CORONER
15. SIGNATURE OF JURY
16. SIGNATURE OF JUDGE
17. SIGNATURE OF CLERK
18. SIGNATURE OF SHERIFF
19. SIGNATURE OF CONSTABLE
20. SIGNATURE OF TOWNSHIP CLERK
21. SIGNATURE OF COUNTY CLERK
22. SIGNATURE OF STATE CLERK
23. SIGNATURE OF SECRETARY
24. SIGNATURE OF ASSISTANT SECRETARY
25. SIGNATURE OF CHIEF CLERK
26. SIGNATURE OF CHIEF OF POLICE
27. SIGNATURE OF CHIEF OF FIRE DEPARTMENT
28. SIGNATURE OF CHIEF OF SANITARY DEPARTMENT
29. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT
30. SIGNATURE OF CHIEF OF MENTAL DEPARTMENT
31. SIGNATURE OF CHIEF OF PHYSICAL DEPARTMENT
32. SIGNATURE OF CHIEF OF CHEMICAL DEPARTMENT
33. SIGNATURE OF CHIEF OF BOTANICAL DEPARTMENT
34. SIGNATURE OF CHIEF OF ZOOLOGICAL DEPARTMENT
35. SIGNATURE OF CHIEF OF AGRICULTURAL DEPARTMENT
36. SIGNATURE OF CHIEF OF MINING DEPARTMENT
37. SIGNATURE OF CHIEF OF MANUFACTURING DEPARTMENT
38. SIGNATURE OF CHIEF OF COMMERCE DEPARTMENT
39. SIGNATURE OF CHIEF OF TRANSPORTATION DEPARTMENT
40. SIGNATURE OF CHIEF OF EDUCATION DEPARTMENT
41. SIGNATURE OF CHIEF OF PUBLIC WORKS DEPARTMENT
42. SIGNATURE OF CHIEF OF PUBLIC SAFETY DEPARTMENT
43. SIGNATURE OF CHIEF OF PUBLIC HEALTH DEPARTMENT
44. SIGNATURE OF CHIEF OF PUBLIC WELFARE DEPARTMENT
45. SIGNATURE OF CHIEF OF PUBLIC UTILITIES DEPARTMENT
46. SIGNATURE OF CHIEF OF PUBLIC INSTRUCTION DEPARTMENT
47. SIGNATURE OF CHIEF OF PUBLIC RELATIONS DEPARTMENT
48. SIGNATURE OF CHIEF OF PUBLIC INFORMATION DEPARTMENT
49. SIGNATURE OF CHIEF OF PUBLIC AFFAIRS DEPARTMENT
50. SIGNATURE OF CHIEF OF PUBLIC SERVICE DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02232

2229

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. LENGTH OF STAY IN 1b adm. 6-14-58			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				d. STREET ADDRESS 509 OURNAY RD.			
3. NAME OF DECEASED (Type or print) First MAUDE Middle NEWBIGIN Last NEWBIGIN				4. DATE OF DEATH Month Feb. Day 6 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-1879	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 59 Min.		10. OCCUPATION (Give kind of work done or business, or working life, even if retired) Business woman		11. BIRTHPLACE (State or foreign country) Missouri	
10b. KIND OF BUSINESS OR INDUSTRY Public Relations		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert G Newbegin			
14. MOTHER'S MAIDEN NAME Mary V. Van Dillen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 691-53-3853		17. INFORMANT Hospital Records, Laurel Sanitarium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant neoplasm of cervix uteri (171) DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (d) _____				INTERVAL BETWEEN ONSET AND DEATH 7 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dementia due to cerebral arteriosclerosis (334)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. Month 19 Day 19 Year 1959 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Laurel				20g. (County) Prince George's		20h. (State) Maryland	
21. I certify that I attended the deceased from 6-14 , 19 58 to 2-6 , 19 59 , that I last saw the deceased alive on 2-6 , 19 59 , and that death occurred at 2:47 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Linda P. Kraemer M.D.				ADDRESS (Street, city or town, state) Laurel Sanitarium			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				DATE SIGNED 2-6-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/6/59		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Schenker & Sons - Balto 17th				24a. REC'D BY REGISTRAR FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2230

CERTIFICATE OF DEATH

Reg. Dist. No.

02233

1. PLACE OF DEATH o. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
c. LENGTH OF STAY IN 1b <u>6 Hr 22 Min</u>		d. STREET ADDRESS <u>5th and Gorman Avenue Apt 4 No 4 Laurel Manor Ct</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Notarberardino</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/59</u>
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gerardo Richard Notarberardino</u>		14. MOTHER'S MAIDEN NAME <u>Marcia Ann O'Donnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Marcia A Notarberardino, Mother</u>	
17. INFORMANT <u>Laurel</u> Address <u>4 Laurel Manor Ct. Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Atelectasis</u> 773.0 DUE TO <u>(Pulmonary Hypertension, etc.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 11 1959</u> , to <u>FEB 11 1959</u> , that I last saw the deceased alive on <u>FEB 11 1959</u> , and that death occurred at <u>8:16 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Buell</u> M.D. <u>402 Main St Laurel Md 2/11/59</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. John Buell</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>FEB 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2231

CERTIFICATE OF DEATH

Reg. Dist. No.

02234

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 35 Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			d. STREET ADDRESS 5905 Forest Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Constantine Francis Novicke			4. DATE OF DEATH Month Day Year February 11 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/87		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Gov't Printing Office		11. BIRTHPLACE (State or foreign country) St. Paul, Minn.	
13. FATHER'S NAME Andrew Novicke (Nowicki)			14. MOTHER'S MAIDEN NAME Anna Ross		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Gordon A. Novicke, 5804 Dewey St., Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Rh. Cor. Art occlusion. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis HTN. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DISS. LUPUS ERYTHEMATOSUS, RHEUMATOID ARTHRITIS (b) CA of VAINARY BLADDER, ULCERATIVE COLITIS					INTERVAL BETWEEN ONSET AND DEATH 4 hrs 6 YRS
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Jan 1954 , 19____, to 11 Feb , 19 59 , that I last saw the deceased alive on 11 Feb , 19 59 , and that death occurred at 10:55PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave., Cheverly, Md. DATE SIGNED 2/12/1959					
ACTUAL SIGNATURE John Kehoe		PHYSICIAN'S NAME (Type) John Kehoe			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14th, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.		24a. REC'D BY REGISTRAR DATE FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2232

CERTIFICATE OF DEATH

Reg. Dist. No.

02235

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph Francis Orlando</u>				4. DATE OF DEATH <u>Feb. 8 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/13 03</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician--Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Orlando</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Kingini</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>578-09-4707</u>		17. INFORMANT <u>Mrs. Marion E. Orlando</u> Address <u>Hyattsville P.O. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 weeks</u> <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/27</u> , 19 <u>58</u> , to <u>2/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>59</u> , and that death occurred at <u>10:20 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon L. Gallin M.D.</u>				DATE SIGNED <u>2/8/59</u>			
PHYSICIAN'S NAME (Type) <u>Leon L. Gallin M.D.</u>				ADDRESS (Street, city or town, state) <u>7206 Colmar Rd. Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11th, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Pr. Geo. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>				24a. RECEIVED BY REGISTRAR <u>FEB 10 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2233

CERTIFICATE OF DEATH

03467

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Hrs 15 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15 d. STREET ADDRESS 3200 Kenilworth Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl Pleasants				4. DATE OF DEATH Month 2 Day 21 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-21-59	
9. AGE (In years last birthday) yrs. 2		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Walter Clement Pleasant			
14. MOTHER'S MAIDEN NAME Gay Atkinson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO (b) 2 Hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 2 Hrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/21 , 19 59 , to 2/21 , 19 59 , that I last saw the deceased alive on 2/21 , 19 59 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3308 Perry St. Mt. Rainier, Md. ACTUAL SIGNATURE C. C. Hageage M.D. DATE SIGNED 2/24/59 PHYSICIAN'S NAME (Type) Dr. C. Hageage							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 3/2/59		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr. ADDRESS Administrator.				24a. REC'D BY REGISTRAR MAR 11 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

2077243XVV

CERTIFICATE OF DEATH

1921

Name of deceased		Sex		Age	
Date of death		Place of death		Cause of death	
Occupation		Usual residence		Manner of death	
Signature of physician		Signature of registrar		Signature of informant	
Date of registration		Place of registration		County	
City		State		District	
Town		Village		Post office	
Street		Room		Apartment	
Floor		Building		Block	
Lot		Sublot		Parcel	
Tract		Section		Range	
Township		County		State	
Country		Continent		World	
Universe		Multiverse		Cosmos	
Nebula		Galaxy		Cluster	
Group		Association		League	
Society		Institution		Organization	
Agency		Bureau		Department	
Division		Section		Office	
Room		Suite		Apartment	
Floor		Level		Height	
Depth		Width		Length	
Volume		Area		Perimeter	
Circumference		Diameter		Radius	
Angle		Arc		Sector	
Segment		Chord		Tangent	
Normal		Secant		Chordal	
Radial		Tangential		Normal	
Parallel		Perpendicular		Oblique	
Inclined		Horizontal		Vertical	
Diagonal		Sloped		Steep	
Shallow		Deep		Shallow	
Wide		Narrow		Wide	
Tall		Short		Tall	
Long		Short		Long	
Fast		Slow		Fast	
Quick		Slow		Quick	
Early		Late		Early	
Late		Early		Late	
First		Last		First	
Last		First		Last	
Beginning		End		Beginning	
End		Beginning		End	
Start		Finish		Start	
Finish		Start		Finish	
Open		Close		Open	
Close		Open		Close	
Up		Down		Up	
Down		Up		Down	
Left		Right		Left	
Right		Left		Right	
Forward		Backward		Forward	
Backward		Forward		Backward	
In		Out		In	
Out		In		Out	
Inside		Outside		Inside	
Outside		Inside		Outside	
Within		Without		Within	
Without		Within		Without	
Among		Between		Among	
Between		Among		Between	
Near		Far		Near	
Far		Near		Far	
Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
From		To		From	
To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
Off		On		Off	
At		From		At	
From		At		From	
In		Out of		In	
Out of		In		Out of	
Into		Out of		Into	
Out of		Into		Out of	
Through		Over		Through	
Over		Through		Over	
Under		Above		Under	
Above		Under		Above	
Below		Above		Below	
Above		Below		Above	
Near		Far		Near	
Far		Near		Far	
Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
From		To		From	
To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
Off		On		Off	
At		From		At	
From		At		From	
In		Out of		In	
Out of		In		Out of	
Into		Out of		Into	
Out of		Into		Out of	
Through		Over		Through	
Over		Through		Over	
Under		Above		Under	
Above		Under		Above	
Below		Above		Below	
Above		Below		Above	
Near		Far		Near	
Far		Near		Far	
Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
From		To		From	
To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
Off		On		Off	
At		From		At	
From		At		From	
In		Out of		In	
Out of		In		Out of	
Into		Out of		Into	
Out of		Into		Out of	
Through		Over		Through	
Over		Through		Over	
Under		Above		Under	
Above		Under		Above	
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Near		Far		Near	
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Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
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To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
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Out of		In		Out of	
Into		Out of		Into	
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Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
From		To		From	
To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
Off		On		Off	
At		From		At	
From		At		From	
In		Out of		In	
Out of		In		Out of	
Into		Out of		Into	
Out of		Into		Out of	
Through		Over		Through	
Over		Through		Over	
Under		Above		Under	
Above		Under		Above	
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Above		Below		Above	
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Far		Near		Far	
Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
From		To		From	
To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
Off		On		Off	
At		From		At	
From		At		From	
In		Out of		In	
Out of		In		Out of	
Into		Out of		Into	
Out of		Into		Out of	
Through		Over		Through	
Over		Through		Over	
Under		Above		Under	
Above		Under		Above	
Below		Above		Below	
Above		Below		Above	
Near		Far		Near	
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Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
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Down to		Up to		Down to	
From		To		From	
To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
Off		On		Off	
At		From		At	
From		At		From	
In		Out of		In	
Out of		In		Out of	
Into		Out of		Into	
Out of		Into		Out of	
Through		Over		Through	
Over		Through		Over	
Under		Above		Under	
Above		Under		Above	
Below		Above		Below	
Above		Below		Above	
Near		Far		Near	
Far		Near		Far	
Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
From		To		From	
To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
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At		From		At	
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In		Out of		In	
Out of		In		Out of	
Into		Out of		Into	
Out of		Into		Out of	
Through		Over		Through	
Over		Through		Over	
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Near		Far		Near	
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Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
From		To		From	
To		From		To	
By		Through		By	
Through		By		Through	
Via		By way of		Via	
By way of		Via		By way of	
On		Off		On	
Off		On		Off	
At		From		At	
From		At		From	
In		Out of		In	
Out of		In		Out of	
Into		Out of		Into	
Out of		Into		Out of	
Through		Over		Through	
Over		Through		Over	
Under		Above		Under	
Above		Under		Above	
Below		Above		Below	
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Near		Far		Near	
Far		Near		Far	
Close		Distant		Close	
Distant		Close		Distant	
Nearby		Remote		Nearby	
Remote		Nearby		Remote	
Adjacent		Opposite		Adjacent	
Opposite		Adjacent		Opposite	
Facing		Back		Facing	
Back		Facing		Back	
Towards		Away from		Towards	
Away from		Towards		Away from	
Up to		Down to		Up to	
Down to		Up to		Down to	
From		To		From	
To		From		To	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2185

CERTIFICATE OF DEATH

Reg. Dist. No.

02236

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE, MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7218 WINTER PLACE</u>				d. STREET ADDRESS <u>17218 WINTER PLACE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL E. POWERS</u>				4. DATE OF DEATH Month Day Year <u>FEB. 17, 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 14, 1909</u>		9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PRUDENTIAL INS CO</u>		11. BIRTHPLACE (State or foreign country) <u>TUCKER COUNTY, W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ZACHARIAH JACOB POWERS</u>				14. MOTHER'S MAIDEN NAME <u>LILLIE E. COSNER.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. LILLIE E. POWERS, 7218 WINTER PLACE.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>							<u>Sudden</u>
420.1 DUE TO <u>Coronary Artery disease</u>							<u>14 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic and Hypertension</u>							<u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/28, 1957</u> to <u>2-17, 1959</u> , that I last saw the deceased alive on <u>2-13, 1959</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis X. Richardson</u>				ADDRESS (Street, city or town, state) <u>7717 Alaska Ave</u>			
PHYSICIAN'S NAME (Type) <u>FRANCIS X. RICHARDSON</u>				DATE SIGNED <u>2/17/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ROGS RD. HATTISVILLE, POTOMAC MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Canal St NW. DC</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1132

File 1132

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION High School	
11. DECEASED IN A PRIVATE RESIDENCE Yes		12. DECEASED IN A PUBLIC PLACE No		13. DECEASED IN A HOSPITAL No		14. DECEASED IN A NURSING HOME No		15. DECEASED IN A PRISON No	
16. DECEASED IN A PLACE OTHER THAN ABOVE No		17. DECEASED IN A PLACE OTHER THAN ABOVE No		18. DECEASED IN A PLACE OTHER THAN ABOVE No		19. DECEASED IN A PLACE OTHER THAN ABOVE No		20. DECEASED IN A PLACE OTHER THAN ABOVE No	
21. DECEASED IN A PLACE OTHER THAN ABOVE No		22. DECEASED IN A PLACE OTHER THAN ABOVE No		23. DECEASED IN A PLACE OTHER THAN ABOVE No		24. DECEASED IN A PLACE OTHER THAN ABOVE No		25. DECEASED IN A PLACE OTHER THAN ABOVE No	
26. DECEASED IN A PLACE OTHER THAN ABOVE No		27. DECEASED IN A PLACE OTHER THAN ABOVE No		28. DECEASED IN A PLACE OTHER THAN ABOVE No		29. DECEASED IN A PLACE OTHER THAN ABOVE No		30. DECEASED IN A PLACE OTHER THAN ABOVE No	
31. DECEASED IN A PLACE OTHER THAN ABOVE No		32. DECEASED IN A PLACE OTHER THAN ABOVE No		33. DECEASED IN A PLACE OTHER THAN ABOVE No		34. DECEASED IN A PLACE OTHER THAN ABOVE No		35. DECEASED IN A PLACE OTHER THAN ABOVE No	
36. DECEASED IN A PLACE OTHER THAN ABOVE No		37. DECEASED IN A PLACE OTHER THAN ABOVE No		38. DECEASED IN A PLACE OTHER THAN ABOVE No		39. DECEASED IN A PLACE OTHER THAN ABOVE No		40. DECEASED IN A PLACE OTHER THAN ABOVE No	
41. DECEASED IN A PLACE OTHER THAN ABOVE No		42. DECEASED IN A PLACE OTHER THAN ABOVE No		43. DECEASED IN A PLACE OTHER THAN ABOVE No		44. DECEASED IN A PLACE OTHER THAN ABOVE No		45. DECEASED IN A PLACE OTHER THAN ABOVE No	
46. DECEASED IN A PLACE OTHER THAN ABOVE No		47. DECEASED IN A PLACE OTHER THAN ABOVE No		48. DECEASED IN A PLACE OTHER THAN ABOVE No		49. DECEASED IN A PLACE OTHER THAN ABOVE No		50. DECEASED IN A PLACE OTHER THAN ABOVE No	
51. DECEASED IN A PLACE OTHER THAN ABOVE No		52. DECEASED IN A PLACE OTHER THAN ABOVE No		53. DECEASED IN A PLACE OTHER THAN ABOVE No		54. DECEASED IN A PLACE OTHER THAN ABOVE No		55. DECEASED IN A PLACE OTHER THAN ABOVE No	
56. DECEASED IN A PLACE OTHER THAN ABOVE No		57. DECEASED IN A PLACE OTHER THAN ABOVE No		58. DECEASED IN A PLACE OTHER THAN ABOVE No		59. DECEASED IN A PLACE OTHER THAN ABOVE No		60. DECEASED IN A PLACE OTHER THAN ABOVE No	
61. DECEASED IN A PLACE OTHER THAN ABOVE No		62. DECEASED IN A PLACE OTHER THAN ABOVE No		63. DECEASED IN A PLACE OTHER THAN ABOVE No		64. DECEASED IN A PLACE OTHER THAN ABOVE No		65. DECEASED IN A PLACE OTHER THAN ABOVE No	
66. DECEASED IN A PLACE OTHER THAN ABOVE No		67. DECEASED IN A PLACE OTHER THAN ABOVE No		68. DECEASED IN A PLACE OTHER THAN ABOVE No		69. DECEASED IN A PLACE OTHER THAN ABOVE No		70. DECEASED IN A PLACE OTHER THAN ABOVE No	
71. DECEASED IN A PLACE OTHER THAN ABOVE No		72. DECEASED IN A PLACE OTHER THAN ABOVE No		73. DECEASED IN A PLACE OTHER THAN ABOVE No		74. DECEASED IN A PLACE OTHER THAN ABOVE No		75. DECEASED IN A PLACE OTHER THAN ABOVE No	
76. DECEASED IN A PLACE OTHER THAN ABOVE No		77. DECEASED IN A PLACE OTHER THAN ABOVE No		78. DECEASED IN A PLACE OTHER THAN ABOVE No		79. DECEASED IN A PLACE OTHER THAN ABOVE No		80. DECEASED IN A PLACE OTHER THAN ABOVE No	
81. DECEASED IN A PLACE OTHER THAN ABOVE No		82. DECEASED IN A PLACE OTHER THAN ABOVE No		83. DECEASED IN A PLACE OTHER THAN ABOVE No		84. DECEASED IN A PLACE OTHER THAN ABOVE No		85. DECEASED IN A PLACE OTHER THAN ABOVE No	
86. DECEASED IN A PLACE OTHER THAN ABOVE No		87. DECEASED IN A PLACE OTHER THAN ABOVE No		88. DECEASED IN A PLACE OTHER THAN ABOVE No		89. DECEASED IN A PLACE OTHER THAN ABOVE No		90. DECEASED IN A PLACE OTHER THAN ABOVE No	
91. DECEASED IN A PLACE OTHER THAN ABOVE No		92. DECEASED IN A PLACE OTHER THAN ABOVE No		93. DECEASED IN A PLACE OTHER THAN ABOVE No		94. DECEASED IN A PLACE OTHER THAN ABOVE No		95. DECEASED IN A PLACE OTHER THAN ABOVE No	
96. DECEASED IN A PLACE OTHER THAN ABOVE No		97. DECEASED IN A PLACE OTHER THAN ABOVE No		98. DECEASED IN A PLACE OTHER THAN ABOVE No		99. DECEASED IN A PLACE OTHER THAN ABOVE No		100. DECEASED IN A PLACE OTHER THAN ABOVE No	

RECEIVED
BALTIMORE
MAY 10 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2234

CERTIFICATE OF DEATH

02237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b <u>22 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> d. STREET ADDRESS <u>/</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Basil</u> Middle <u>Queen</u> Last <u>Queen</u> 4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1959</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 27 1897</u> 9. AGE (In years last birthday) <u>61</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Race & Ass.</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Queen Sr.</u> 14. MOTHER'S MAIDEN NAME <u>Mary Ellen Queen</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>/</u> 16. SOCIAL SECURITY NO. <u>/</u> 17. INFORMANT <u>Thomas Queen's Brother, 1532 Constitution N.E. Washington, D.C.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrotic Syndrome</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Hypertensive Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>/</u> INTERVAL BETWEEN ONSET AND DEATH <u>/</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>/</u> 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>/</u> 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6311 Bowie Ave. Cheverly, Md.</u> DATE SIGNED <u>Feb 25 1959</u> ACTUAL SIGNATURE <u>D. H. Haysman</u> M.D. PHYSICIAN'S NAME (Type)				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>2-26-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>389 L'Anse-au-Loup Island Ave. Wash. D.C.</u> 22d. LOCATION (City, town, or county) (State) <u>Bowie, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Trazz's Funeral Home</u> 24a. REC'D BY REGISTRAR DATE <u>FEB 25 '59</u> 24b. REGISTRAR'S SIGNATURE <u>C. L. Haysman</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2265

CERTIFICATE OF DEATH

02238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 1 yr., 9 mos., and 7 days		d. STREET ADDRESS 817 Longfellow St., N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Laura V. Ramseur		4. DATE OF DEATH Month Day Year 2 15 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/67
9. AGE (In years last birthday) 91		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. - - -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Monroe Clark		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Cleo M. Fowler		Address Granddaughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) -			
INTERVAL BETWEEN ONSET AND DEATH 10 yrs., 20 yrs.,			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) organisms. Pulmonary tuberculosis; urinary tract infection, chronic, multiple;			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/8/ , 19 57 , to 2/15/ , 19 59 , that I last saw the deceased alive on 2/15/ , 19 59 , and that death occurred at 2:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 2/15/59	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BLINDING CREMATION REMOVAL (Specify)	22b. DATE THEREOF 2-17-59	22c. NAME OF CEMETERY OR CREMATORY WASH. D.C.	22d. LOCATION (City, town, or county) (State) WASH. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Foynes, Jas. A. Mahoney		24. REC'D BY REGISTRAR DATE FEB 19 '59	
ADDRESS 116 Miss Ave. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
by the hospital or attending physician.
FOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2235

CERTIFICATE OF DEATH

02239

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X District Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>7001 Walker Mill Road. S.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>C</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/73</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Samuel Hayes</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Clarence Farrell</u>		Address <u>6997 Walker Mill Rd. Dist Heights Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>with arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>57</u> , to <u>Feb 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>February 25</u> , 19 <u>59</u> , and that death occurred at <u>9:23 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u>		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>	
PHYSICIAN'S NAME (Type) <u>WM. BRAININ</u>		DATE SIGNED <u>2/25/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ephraim</u>
22d. LOCATION (City, town, or county) <u>Forestville, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Inc. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>2.27.59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. SIGNATURE OF WITNESSES</p>	

2180

CERTIFICATE OF DEATH

Reg. Dist. No.

02240

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville, Md.				c. LENGTH OF STAY IN 1b 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6514 Medwick Drive				d. STREET ADDRESS 6514 Medwick Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Austin Theodore Rollins				4. DATE OF DEATH Month Day Year Feb 5, 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1873	
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alburton B Rollins				14. MOTHER'S MAIDEN NAME Sidney Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Mary Ernest		Address West Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure 444X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/24, 1959, to 2/5, 1959, that I last saw the deceased alive on 2/5, 1959, and that death occurred at 8:30 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernesta L. Brown		M.D. 7006 New Hampshire Ave		DATE SIGNED 2/5/59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/59		22c. NAME OF CEMETERY OR CREMATORY Shilow Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Shilow Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24. REC'D BY REGISTRAR DATE FEB 9 '59	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02241

Reg. Dist. No.

2236

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival X Silesia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 8251 River View Road	
3. NAME OF DECEASED (Type or print) John Wise Ruefly		4. DATE OF DEATH Month February Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 19, 1905
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10b. KIND OF BUSINESS OR INDUSTRY Produce	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oren Ruefly		14. MOTHER'S MAIDEN NAME Lucille Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 901 Owens Road S.E.	
17. INFORMANT Benjamin Ruefly Oxon Hill, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Gastric Hemorrhage, acute gastritis (c) Cirrhosis of the liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Gastric Hemorrhage, acute gastritis (c) Cirrhosis of the liver			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED February 1, 1959	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 3-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Southland Md
23. FUNERAL DIRECTOR'S SIGNATURE Sammons Brothers		24. REG'D BY REGISTRAR DATE FEB 4 '59	
ADDRESS 1661-gd Hope Rd		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

2266

Item 5 Film 258 2-18-59 et

02242

2266

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>	
c. LENGTH OF STAY IN 1b <u>7 wks.</u>		d. STREET ADDRESS <u>13705 37th Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prin Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pauline</u>	First <u>Pauline</u> Middle <u>Olga</u> Last <u>Nyden</u>	4. DATE OF DEATH <u>Feb.</u> Month <u>12</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Gotten Kiene</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Cooke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerosis</u> DUE TO (c) <u>1 hr.</u> 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 21</u> , 1958, to <u>Feb. 12</u> , 1959, that I last saw the deceased alive on <u>Feb. 12</u> , 1959, and that death occurred at <u>4:15 p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. C. Hageage</u>		ADDRESS (Street, city or town, state) <u>3308 Perry St. Mt. Rainier, Md.</u> DATE SIGNED <u>2/12/59</u>	
PHYSICIAN'S NAME (Type) <u>C. C. Hageage M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>2/16/1959</u>	<u>North Lincoln Cem</u>	<u>Column Manor R. Geo. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co - Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 17 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Fraser</u>	

CERTIFICATE OF DEATH

3276

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2181

02243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr.Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 55 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4309 Farragut Street		e. STREET ADDRESS 4309 Farragut Street	
3. NAME OF DECEASED (Type or print) James Severe		4. DATE OF DEATH Month February Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1873
9. AGE (in years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. KIND OF BUSINESS OR INDUSTRY Engineer	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY U.S.A.	
15. FATHER'S NAME James Severe		16. MOTHER'S MAIDEN NAME Charlotte Elizabeth Shipley	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT Martha Severe; same address as # 2.		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 19, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/21/59	22c. NAME OF CEMETERY OR CREMATORY George Washington	22d. LOCATION (City, town, or county) (State) Hyattsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24. REC'D BY REGISTRAR 4739 Balto. Ave. Hyattsville, Maryland	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE FEB 24 '59	

MISSISSIPPI
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 26

1. Name of Deceased: James Earl Ray
2. Date of Birth: May 22, 1928
3. Sex: Male
4. Race: White
5. Marital Status: Single
6. Occupation: Author
7. Usual Residence: Room 306, 535 South Main Street, Memphis, Tennessee
8. Date of Death: May 14, 1968
9. Place of Death: Room 306, 535 South Main Street, Memphis, Tennessee
10. Cause of Death: Gunshot wound to the chest
11. Manner of Death: Suicide
12. Signature of Medical Examiner: Dr. J. H. Hume
13. Signature of Coroner: Dr. J. H. Hume
14. Signature of Registrar: Dr. J. H. Hume
15. Signature of Medical Examiner's Assistant: Dr. J. H. Hume
16. Signature of Coroner's Assistant: Dr. J. H. Hume
17. Signature of Registrar's Assistant: Dr. J. H. Hume
18. Signature of Medical Examiner's Assistant's Assistant: Dr. J. H. Hume
19. Signature of Coroner's Assistant's Assistant: Dr. J. H. Hume
20. Signature of Registrar's Assistant's Assistant: Dr. J. H. Hume

2267

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md		c. LENGTH OF STAY IN 1b 15 Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eleven Cedars Nursing Home		d. STREET ADDRESS 6709 Queens Chapel Road, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dora Middle Belle Last Stack		4. DATE OF DEATH Month February 14, Day 19, Year 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Wesley Lawrence		14. MOTHER'S MAIDEN NAME Irene Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT N L Stack		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic sclerotic cardio-vascular disease DUE TO (c) disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 58 Feb 1959, to Feb 14 1959, that I last saw the deceased alive on Feb 14 1959, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.L. Etienne		DATE SIGNED 4/15/59	
PHYSICIAN'S NAME (Type) W.L. ETIENNE		College Park, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation	22b. DATE THEREOF 2/15/59	22c. NAME OF CEMETERY OR CREMATORY Charlotte	22d. LOCATION (City, town, or county) (State) North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE FEB 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02245

2182

Item 1 Film G239 3-2-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN lb 2 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3304 Lancer Drive (At home)		e. STREET ADDRESS 6714 Red Top Road	
3. NAME OF DECEASED (Type or print) Nina Anne Stein		4. DATE OF DEATH Month February Day 23 Year 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-59
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Leo Stein		14. MOTHER'S MAIDEN NAME Anna Kate Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Leo Stein; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 325.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of food (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongoloid			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED February 22, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/24/59	22c. NAME OF CEMETERY OR CREMATORY St. Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Busch's SONS Hyattsville Md.		24. REC'D BY REGISTRAR DATE FEB 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEPT.

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF BIRTH: _____

RESIDENCE: _____
OCCUPATION: _____

DATE OF DEATH: _____
PLACE OF DEATH: _____

CAUSE OF DEATH: _____
MANNER OF DEATH: _____

TIME OF DEATH: _____
PLACE OF DEATH: _____

NAME OF PHYSICIAN: _____
ADDRESS: _____

SIGNATURE OF PHYSICIAN: _____
DATE: _____

NAME OF MEDICAL EXAMINER: _____
ADDRESS: _____

SIGNATURE OF MEDICAL EXAMINER: _____
DATE: _____

NAME OF CORONER: _____
ADDRESS: _____

SIGNATURE OF CORONER: _____
DATE: _____

NAME OF JURY: _____
ADDRESS: _____

SIGNATURE OF JURY: _____
DATE: _____

NAME OF JURY: _____
ADDRESS: _____

SIGNATURE OF JURY: _____
DATE: _____

NAME OF JURY: _____
ADDRESS: _____

SIGNATURE OF JURY: _____
DATE: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02246

2237

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington 47X-3		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 3525 Davis Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James Montgomery Sullivan			4. DATE OF DEATH Month February Day 19 Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-39		9. AGE (in years last birthday) 19 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. manager		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Richard Sullivan			14. MOTHER'S MAIDEN NAME Virginia Saul		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-50-9970		17. INFORMANT Address Richard T. Sullivan, M.D. same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 822X DUE TO Conditions, if any, which gave rise to immediate cause (b) Severance of inferior vena cava, rupture of liver and spleen (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operator of an automobile that went out of control and turned over.					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile that went out of control and turned over.			
20c. TIME OF INJURY Month, Day, Year Hour 1.00 a. m. 2-19- 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Mt. Rainier, Pr. Geo.		(County) Md.		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED February 19, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-21-59		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEM. WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol		ADDRESS 2224 - Wis. Ave. N.W.		24a. REC'D BY REGISTRAR FEB 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State and of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
AGE
SEX

DATE OF DEATH
PLACE OF DEATH
CITY AND COUNTY

CAUSE OF DEATH
MANNER OF DEATH

DATE OF EXAMINATION
PLACE OF EXAMINATION
NAME OF EXAMINER

SIGNATURE OF EXAMINER

DECEASED'S NAME AND ADDRESS

DECEASED'S RESIDENCE
CITY AND COUNTY

18

DECEASED'S NAME AND ADDRESS

DECEASED'S RESIDENCE

DECEASED'S NAME AND ADDRESS

DECEASED'S RESIDENCE

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02247

2238

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dillon Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 5213 G Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Jacquelin Elaine Sweat			4. DATE OF DEATH Month February Day 23 Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1958		9. AGE (in years last birthday) yrs. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Vernon Earl Sweat		
14. MOTHER'S MAIDEN NAME Nancy Remos			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. none			17. INFORMANT Address Vernon E. Sweat, same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington Va		22e. (State) Virginia		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE FEB 25 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Official Record

Deceased: [Name] [Address] [City] [State] [Country]
Date of Birth: [Month] [Day] [Year] [Age] [Sex] [Race]

Place of Birth: [Location] [State] [Country]
Date of Death: [Month] [Day] [Year] [Time] [Place]

Cause of Death: [Description]
Manner of Death: [Description]
Contributing Factors: [Description]

Signature of Medical Examiner: [Name]
Signature of Coroner: [Name]
Signature of Registrar: [Name]

Witnesses: [Name] [Address] [City] [State] [Country]
[Name] [Address] [City] [State] [Country]

Attest: [Signature]
[Signature]
[Signature]

Filed for Record: [Date]
[Signature]
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02248

2268

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PR. Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5115-LOGAN ST. SE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>J.</u> Last <u>TAYLOR</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 16-1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Jane Porch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>William H. Taylor</u>		Address <u>5115-Logan St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RT Inguinal Hernia Duration unknown</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. s. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>Feb. 7, 1959</u> , that I last saw the deceased alive on <u>Feb. 7, 1959</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C. Van Vatta</u>		M.D. <u>5440 Silver Hill Rd SE</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C. VAN VATTA</u>		<u>Washington 28 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emporia Cemetery</u>
22d. LOCATION (City, town, or county) <u>Emporia</u>		(State) <u>VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sevinens Bros. Funeral Home</u>		ADDRESS <u>1661-Good Hope Rd. SE. WASH DC</u>	24. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 9 '59</u>
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u> </u>	

CERTIFICATE OF DEATH

3368

<p>1. Name of deceased: <i>Pr. Geo.</i></p>		<p>2. Date of death: <i>May 1901</i></p>	
<p>3. Place of death: <i>Pr. Geo.</i></p>		<p>4. Age of deceased: <i>70</i></p>	
<p>5. Sex: <i>Male</i></p>		<p>6. Race: <i>White</i></p>	
<p>7. Cause of death: <i>Heart</i></p>		<p>8. Duration of illness: <i>1 day</i></p>	
<p>9. Name of physician: <i>Dr. J. H. Smith</i></p>		<p>10. Name of undertaker: <i>John</i></p>	
<p>11. Name of informant: <i>John</i></p>		<p>12. Address of informant: <i>1234</i></p>	
<p>13. Signature of physician: <i>[Signature]</i></p>		<p>14. Signature of informant: <i>[Signature]</i></p>	

15. Date of filing: *May 1901*

16. Name of registrar: *[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
2269
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

02249

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>SAME</u> b. COUNTY <u>16</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE</u>	c. LENGTH OF STAY IN 1b <u>78 yr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TENTH & MAPLE ST</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY THIRLES</u>		4. DATE OF DEATH Month Day Year <u>Feb 11 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 10, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RAILROAD CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EIKRIDGE MD</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>STEPHEN H THIRLES</u>		14. MOTHER'S MAIDEN NAME <u>SARAH WIRT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>717-07-8111</u>	
17. INFORMANT <u>WIFE DAISY V THIRLES - SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CANCER OF RECTUM</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> -Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG 1930</u> to <u>PRESENT</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>59</u> , and that death occurred at <u>245</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>402 MAIN ST - LAUREL MD</u> <u>2/11/59</u>			
ACTUAL SIGNATURE <u>J. R. Buell</u>		M.D. <u>DRS M. Sceney & Buell</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2270

CERTIFICATE OF DEATH

02250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Chaptico St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural T. B		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chaptico 18X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Charles S. Thomas		4. DATE OF DEATH February 18, 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1959
9. AGE (In years last birthday) yrs. 14		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chaptico, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Aloysius Thomas		14. MOTHER'S MAIDEN NAME Mary Frances Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George A. Thomas		Address Chaptico, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased Intracranial Pressure 760.0 DUE TO (b) Subdural Hematoma DUE TO (c) Birth Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH Unknown 2 wks 2 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Birth
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Feb 1959 to 18 Feb 1959, that I last saw the deceased alive on 18 Feb 1959, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE David L Mossman		DATE SIGNED ADDRESS (Street, city or town, state) Mechanicsville, Maryland	
PHYSICIAN'S NAME (Type) DAVID L MOSSMAN		Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/59	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town, or county) (State) Morgantown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR DATE 2 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02251

Reg. Dist. No.

2239

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hosp.		e. STREET ADDRESS 6211 Field Street	
3. NAME OF DECEASED (Type or print) Ruby Frances Moran Todd		4. DATE OF DEATH February 26 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/25
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas A. Moran		14. MOTHER'S MAIDEN NAME Ruby Bunce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT James G. Todd		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-27-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/59	
22c. NAME OF CEMETERY OR CREMATORY Lib. Hall		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc.		24a. REC'D BY REGISTRAR DATE MAR 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2240
CERTIFICATE OF DEATH

Reg. Dist. No.

02252

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>56 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Tompkins</u>				4. DATE OF DEATH <u>February 26 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/6/06</u>	
9. AGE (In years last birthday) <u>52 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>150X Broncho pneumonia left, 2 abscesses</u> DUE TO (b) <u>Spidermoid Ca B to Esophagus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>December 31, 1958</u> , to <u>February 26, 1959</u> , that I last saw the deceased alive on <u>February 26, 1959</u> , and that death occurred at <u>8:35A M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David S. Clayman</u>				ADDRESS (Street, city or town, state) <u>634 Belts Ave. Riverdale Md</u>			
DATE SIGNED <u>2/22/59</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>3-3-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Watson</u>				ADDRESS <u>1700 Vermont Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>498</u> DATE <u>2-27-59</u>	
24b. REGISTRAR'S SIGNATURE <u>John D. Watson</u>				MAR 2 1959			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2271

CERTIFICATE OF DEATH

02252

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Landover Hills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7105 - Varnum street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Walter</u> Last <u>Van Horn</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>1st</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1866</u>	9. AGE (In years lost birthday) yrs. <u>92</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Seneca C. Van Horn</u>				14. MOTHER'S M maiden NAME <u>Ann Catherine Lonkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Adeline B. Roddy</u> Address <u>as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart & Kidney</u> 442X DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>renal</u> DUE TO (c) <u>chronic glomerulonephritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval BETWEEN ONSET AND DEATH 30 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/27</u> , 19 <u>59</u> to <u>2/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/1</u> , 19 <u>59</u> , and that death occurred at <u>3:30</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George J. Hageage</u> M.D.				ADDRESS (Street, city or town, state) <u>3717-38th Ave</u>		DATE SIGNED <u>2/1/59</u>	
PHYSICIAN'S NAME (Type) <u>George J. Hageage</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>			

2272

Item 7 Film G239 3-2-59 et

CERTIFICATE OF DEATH

02254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park Md		c. LENGTH OF STAY IN 1b 17 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4304 Van Bruen St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Mc Naughton Last Vial		4. DATE OF DEATH Month Feb Day 24 , Year 19 59-	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Aug 1889
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Agriculture U of Md.	
11. BIRTH PLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Vial		14. MOTHER'S MAIDEN NAME Carswells D Cragmile	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 219 34 2451	
17. INFORMANT Peter F. Vial		Address Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Ischemic Heart Disease DUE TO (c) 2-3 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 20, 1959 to Feb 24, 1959 , that I last saw the deceased alive on Feb 20, 1959 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. L. Etienne		DATE SIGNED 2/24/59	
PHYSICIAN'S NAME (Type) W. L. ETIENNE		ADDRESS (Street, city or town, state) 4713 Germann Rd College Park, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) transportation 2/26/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY La Grange		22d. LOCATION (City, town, or county) (State) Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR FEB 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 11

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		OCCUPATION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		RELIGION	
PREVIOUS ILLNESS		TREATMENT	
HISTORY OF DEATH		FAMILY HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
DIAGNOSIS		TREATMENT	
PROGNOSIS		FOLLOW-UP	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

2273

CERTIFICATE OF DEATH

02255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 28 DC</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES CO. NEST HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOUISA P</u> Middle <u>WASHINGTON</u> Last <u>WASHINGTON</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>U.S. Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-2-1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Tugood</u>				14. MOTHER'S MAIDEN NAME <u>Ann Dodson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, if unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Blanche Lumbs NY. NY.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none of note</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>58</u> to <u>Feb 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>59</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.				PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u> <u>WASHINGTON 28 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02256

2241

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 5 weeks 41			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 1306 Montgomery Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Ellen S Welling				4. DATE OF DEATH Month Day Year February 27 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12, 1875	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Channing M. Smith				14. MOTHER'S MAIDEN NAME Lucy D. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. —			
17. INFORMANT Address Lucy A. Bass, Laurel, Md							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Ventricular Fibrillation 1 day DUE TO (b) Arteriosclerotic Heart Disease 10 yrs DUE TO (c) Sen. Arteriosclerosis 10 yrs CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric Ulcer + Pancreatic Ulcer INTERVAL BETWEEN ONSET AND DEATH 1 day							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/20, 1938, to 2/27, 1959, that I last saw the deceased alive on 2/26, 1959, and that death occurred at 12:54 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED 2/27/59							
ACTUAL SIGNATURE J. M. WARREN							
PHYSICIAN'S NAME (Type) J. M. WARREN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1, 1959		22c. NAME OF CEMETERY OR CREMATORY St Marks Cem.		22d. LOCATION (City, town, or county) (State) Highland Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS He With Cauldren Laurel Md							
24a. REC'D BY REGISTRAR DATE MAR 3 '59							
24b. REGISTRAR'S SIGNATURE Arthur S. Knead							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02257

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 5 years		d. STREET ADDRESS 6003 37th Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6003- 37th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cora Victoria Werdig		4. DATE OF DEATH February 17 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Clem		14. MOTHER'S MAIDEN NAME Ellen Frances Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Susan Frances Van Horn; same address as #2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED February 17, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR FEB 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02258

2242

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 Hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary J		4. DATE OF DEATH Month Feb Day 4 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 July 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hattie Pickrell		Address Oxen Hill, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulm Cong + edema 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension intensel. renal. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcohol Mellito		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 3, 1959 to February 3, 1959 , that I last saw the deceased alive on February 3, 1959 , and that death occurred at 1:15 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE T. T. Secomand		M.D. Hyattsville, Md. DATE SIGNED 2/4/59	
PHYSICIAN'S NAME (Type) Dr. T. Secomand		Hyattsville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/59	
22c. NAME OF CEMETERY OR CREMATORY St Barnabas Cemetery		22d. LOCATION (City, town, or county) (State) Oxen Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REF. BY REGISTRAR FEB 10 59		DATE 2/4/59	
24b. REGISTRAR'S SIGNATURE Arthur S.			

CERTIFICATE OF DEATH

1942

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G239 3-2-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02259

2243

1. PLACE OF DEATH a. COUNTY: Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P.G. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 LAUREL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		c. LENGTH OF STAY IN 1b 4 Days		d. STREET ADDRESS 407 Montrose Avenue	
3. NAME OF DECEASED (Type or print) Margaret G Wright		First Middle Last		4. DATE OF DEATH Feb. 20 Day Year 19 59	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1881 Dec. 23, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isaac Fisher		14. MOTHER'S MAIDEN NAME Elizabeth - ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Bernhardt Wright Forest Hill Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 x Cerebral infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 16 19 59 to Feb. 20 19 59 , that I last saw the deceased alive on Feb. 20 19 59 , and that death occurred at 8:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE George J. Hager M.D.					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2.23.59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore County		23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.		24a. REC'D BY REGISTRAR FEB 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2274

CERTIFICATE OF DEATH

Reg. Dist. No.

02260

1. PLACE OF DEATH o. COUNTY Prince George Co MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights c. LENGTH OF STAY IN b. 2 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7902 Foster Str e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle ZIELENSKY Last DATE OF DEATH Feb 11 1959				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec 25 1886 73 yrs. 9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Warsaw Poland 12. CITIZEN OF WHAT COUNTRY? American				13. FATHER'S NAME Frank Drust 14. MOTHER'S MAIDEN NAME Ella Drust			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Daughter, Mrs Anna Gardner Address 3902 Foster Str District Heights				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 334X Cardiac Failure DUE TO (b) Dehydration & Emaciation 2 mo. DUE TO (c) Cerebral arteriosclerosis 8 mo. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED White Not white at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 7/27, 1958, to 2/11, 1959, that I last saw the deceased alive on 2/10, 1959, and that death occurred at 10:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Kelvin L. Minchin, M.D. 7200 Marlboro Pike SE Wash DC PHYSICIAN'S NAME (Type) KELVIN L. MINCHIN, M.D. 2/11/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-13-1959 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill 22d. LOCATION (City, town, or county) (State) Suitland Md				23. FUNERAL DIRECTOR'S SIGNATURE J. K. Mathinghy ADDRESS Wash, D.C. 24a. REC'D BY REGISTRAR DATE FEB 13 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

Prince George C.
 District Judge & you

Newspaper, Tribune

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Friends & Family

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KEVIN L. WILSON

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